STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILIDING	00	COMPLETED
		155474	A. BUILDING		05/24/2011
			B. WING	TT ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIEF	₹	l l	WOODIES LANE	
DDEMEN	I HEALTH CARE C	ENTED	l l		
DREWEN	I HEALTH CARE C	ENTER	DREI	MEN, IN46506	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` `	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was fo	or a Recertification and	F0000	The facility requests that this p	
	State Licensure	Survey.		correction be considered its cre	edible
				allegation of compliance.	.C.41.:-
	Survey dates: M	ay 16, 17, 18, 19, 20, 21,		Preparation and/or execution of plan of correction does not cor	<b>I</b>
	22, 23, and 24, 2			admission or agreement by the	<b>I</b>
	22, 23, and 24, 2			provider of the truth of the fact	l l
	Easilia. N1	000506		alleged or conclusions set forth	<b>I</b>
	Facility Number			statement of deficiencies. The	<b>I</b>
	Provider Numbe			of correction is prepared and/o	-
	AIM Number: 1	umber: 100266530		executed solely because it is re	equired
				by the provisions of federal an	d state
	Survey Team:			law.	
	_	N TC - May 16, 17, 18,			
	19, 20, 23, and 2	• • • • • • •			
	Toni Krakowski.				
	Vicki Manuwal,				
		RN- May 16, 17, 18, 19,			
	20, 23, and 24, 2	2011			
	Census Bed Typ	e:			
	SNF/NF: 94				
	Total: 94				
	10ta1. 7T				
	C1 D				
	Census by Payor	Type:			
	Medicare: 6				
	Medicaid: 73				
	Other: 15				
	Total: 94				
	Sample: 19				
	Supplemental Sample: 30				
	Supplemental Sa	шріс. 30			
	These deficienci	es also reflect state			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

4EZC11

Facility ID:

TITLE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 05/24/2011
	ROVIDER OR SUPPLIER		STREET.	ADDRESS, CITY, STATE, ZIP CODE OODIES LANE EN, IN46506	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
		accordance with 410 IAC			
	Quality review c by Bev Faulkner	ompleted on June 1, 2011 , RN			

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	00	COMPL	ETED
		155474	A. BUIL B. WING			05/24/2	011
			B. WINC		DDDEGG OFFY GTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
		ENTED			ODIES LANE		
BKEMEN	I HEALTH CARE C	ENTER		BKEME	N, IN46506		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1 '	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0157	A facility must imm	nediately inform the	I				
SS=E		vith the resident's physician;					
	and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a						
significant change in the resident's physical, mental, or psychosocial status (i.e., a							
	deterioration in health, mental, or						
		is in either life threatening					
1 ' '		cal complications); a need to					
	alter treatment sig	nificantly (i.e., a need to					
discontinue an existing form of treatment due		sting form of treatment due					
		quences, or to commence a					
		nent); or a decision to					
		ge the resident from the					
	facility as specified	d in §483.12(a).					
	The facility must a	Iso promptly notify the					
	-	own, the resident's legal					
		nterested family member					
	-	lange in room or roommate					
		ecified in §483.15(e)(2); or					
		ent rights under Federal or					
	State law or regula	ations as specified in					
	paragraph (b)(1)	of this section.					
	•	ecord and periodically					
		s and phone number of the					
	•	oresentative or interested					
	family member.	otion intomic I	EO	157	F-157 It is the practice of this		06/22/2011
		ation, interview, and	F01	13/	facility to ensure the highest		06/23/2011
		e facility failed to ensure			quality of care is afforded our	-	
		s notified of changes			residents. Consistent with th		
	related to inadeq	uate pain control			practice, the following has be		
	(Resident #40), v	weight loss (Resident			done: The corrective action to		
		ood sugars (Residents			for the residents found to have		
	#80 and #3), and respiratory decline				been affected by the deficien	t	
					practice was: Resident #40	,	
	(Resident #27) for 5 of 5 residents				received her scheduled norce	o at	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		, DDIG	00	COMPL	ETED
		155474	1	LDING		05/24/2	011
			B. WIN		ADDRESS STEV STATE STR SORE		
NAME OF I	PROVIDER OR SUPPLIE	R		1	ADDRESS, CITY, STATE, ZIP CODE		
				1	OODIES LANE		
BREME	N HEALTH CARE C	ENTER		BREME	EN, IN46506		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	reviewed for clin	nical changes in a sample			14:50 on 5/16/11, therefore	no	
	of 19.				notification was required for		
					ongoing pain. The physicia		
	Findings include:				been notified for resident #5		
	Findings include	<del>)</del> .			related to decreased appetit		
					subsequent weight loss with		
	1. Resident #40's clinical record was				orders received. The physic has been notified for resider		
	reviewed on 5/16/11 at 2:35 P.M., and				related to resident's condition		
	indicated diagnoses of, but not limited to:				no new orders received. Th		
	history of sacral/pelvic fracture,				physician was notified for re		
	1				#3 on 03/26/11 and 3/27/11	ordorre	
	osteoporosis, macular degeneration, senile				related to elevated blood su	gars	
	dementia, and osteoarthritis of the hips.				and orders received for insu	_	
					administration. Resident red	ceived	
	During initial to	ur of the locked dementia			additional insulin at the time	per	
	_	at 7:00 A.M., while			physician order. The physic		
		LPN # 2, Resident #40			has been notified for resider		
		·			relative to elevated blood su	-	
	1	ing in her bed. The			with no new orders received		
	1	macing and indicated she			corrective action taken for th		
	was having pain	at the time. LPN #2			residents having the potentia		
	indicated the res	ident had a recent fall and			be affected by the same def practice is:A facility wide aud		
	sustained an irre	parable fractured right			all medical records for the la		
	hip.				days has been conducted to		
	r				evaluate compliance with		
	Dagidant #40	as observed on 5/16/11 at			notification of family and		
					physician related to change	in	
	•	aming out in pain when			condition. Any identified		
	she was pulled u	ip in her bed by LPN #2			concerns lacking notification	have	
	and CNA #5. D	uring interview with LPN			resulted in appropriate		
	#2 at the time, sl	he stated, "We need to get			notifications being made. The		
		N (Norco) in her."			measures put into place and		
		. (1.0100) III IIOI.			systemic change made to en		
	A Diameter A	.1 1 1.5/4/11 + 1.00			the deficient practice does n		
	A Physician's Order, dated 5/4/11 at 1:20				recur is: Licensed nursing st has been in-serviced related		
	P.M., indicated, "Norco 5/325				physician notification regard		
	(Hydrocodone 5mg [milligram]-325 mg				change of condition by the S		
	APAP [acetamin	ophen]) tablets. Give i			Development Coordinator.		
	(one) PO (by mo	1 27			ensure the deficient practice		

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155474	B. WIN			05/24/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
	LUEALTH CARE OF	INTED		1	OODIES LANE	
BREMEN	N HEALTH CARE CE	ENTER		BREME	EN, IN46506	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
IAG			+	IAG	not recur, the monitoring sys	
	l * *	1., 2 P.M., 10 P.M.			established is:A Performance	
	Keep PRN (as needed) Norco order (every 4 hours) for breakthrough pain"				Improvement indicator has b	
	· · ·	o had an order for			established which evaluates	
					compliance with physician notification. The Director of	
	Acetaminophen (	`			Nursing or designee will com	nolete
	"	g. TID and Tramadol 100			the indicator weekly for the fi	
	mg. TID.				month, monthly for the first	
	Danie CD 11				quarter and quarterly thereat with results forwarded to the	
		ent #40's Medication			facility performance improve	l l
	Administration Record (MAR) on 5/16/11				committee for further evaluation	•
	at 12:30 P.M., indicated she had been medicated with Norco (narcotic pain				or resolution. POC Date: 6/2	3/11
	´ `	g. (milligram) at 6:00				
	`	dose)with the next				
	scheduled dose o					
		2:00 P.M. She received				
	650 mg. of aceta	•				
	l `	r analgesic) and 100 mg.				
	of Tramadol (nor	•				
	l ′	00 A.M. Further review				
		cated LPN #2 medicated				
		h the PRN (as needed)				
		2:30 P.M. for her				
	breakthrough pai	n.				
		-0.D.M. D				
		50 P.M., Resident #40				
		nterview she was having				
		right hip and was fearful				
		n bed. Review of her				
		e, indicated she had not				
	~	:00 P.M. scheduled dose				
	1	d received another dose				
		cetaminophen and 100				
	mg. of the Trama	adol at 2:00 P.M. She				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  CO	OMPLETED
u IA BUILDING	JIII EETED
155474 B. WING	24/2011
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER  316 WOODIES LANE	
BREMEN HEALTH CARE CENTER BREMEN, IN46506	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
THE REGULATOR OF ESCHIEFATH THE INTORNATION INC.	DATE
received a PRN dose of Norco at 4:00	
P.M.	
Review of Nurse's Notes indicated the	
following:	
"5/2/11 at 2:00 P.MUp with assist of one	
with walker to meals and BR	
(bathroom)5/3/11 at 9:30 P.MRes. was sitting in Dayroom. Disengaged her	
Mobility Monitor. Observed standing in	
Dayroom got up to go to rm (room). Res.	
lost bal (balance) et (and) fell to floor on	
R side5/4/11 at 8:30 P.MRes. crying	
out in pain, grabbing R hip. Norco given	
after repositioning. Unsuccessfulc/o's	
(complains of) pain with turning to	
change padsagitated with staff while	
turning. Pain #8-#9 (pain scale 0-10 with	
10 being 'worst pain that can be	
imagined') when moving5-5-11 at 7:30	
P.MMedicated for pain #9 at 6P (P.M.)	
with Norcoin severe pain when T & R	
(turned and repositioned)5-6-11 at 9:00	
P.MCries out loudly grabbing at staff	
members in severe pain whenever being T	
& R or ever putting HOB (head of bed) up	
or down5/7/11 at 10:50 P.MT & R q	
(every) 2 hours-cries out loudly, grabbing	
staff arms and clothing-severe pain when	
being T & R5/8/11 at 2:00 P.Mmuch	
discomfort when moved feet	
upmedicated x 1 between routine Norco	
dose5/8/11 at 8:00 P.Mcont.	
(continues) to be in severe pain when	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ĺ		NSTRUCTION 00	(X3) DATE S COMPL	
111,1211111	or conditions	155474	1	LDING	<del></del>	05/24/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	OODIES LANE		
BREMEN	N HEALTH CARE CE	ENTER		1	N, IN46506		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		in meds5/9/11 at 3:53					
		show s/s (signs and					
	symptoms) of pain when moved. PRN						
	medication given5/9/11 at 1:45 P.M.						
		ed yells out at staff,					
	facial grimacing5/9/11 at 6:19 P.M.						
	1 *	P.M. care, routine and					
	1	5/10/11 at 2:00 P.M.					
	as long as still	no pain on routine pain					
		2:00 P.Mmuch					
	discomfort when turned5/11/11 at 9:30						
	P.Msevere pain when care is being						
	given5/12/11 a	t 3:50 P.Mcont. in					
	pain when T & R	25/12/11 at 7:50 P.M.					
	Medicated for	pain #9 at 1800 (6:00					
	P.M.) with some	relief obtained-cont. to					
	moan-cry out, tea	ar at staff's clothing when					
	being T & R5/1	13/11 at 6:30 A.M.					
	Repositioned	and changed and the c/o's					
	of Rt (right) hip j	pain with care5/13/11 at					
	2:25 P.MRes.	yell (sic) out some in					
	pain when turned	l or repositioned by ii (2)					
	assist5/14/11 at	t 6:00 A.MResists					
	being turned due	to increased Rt leg pain					
	with movement	.5/14/11 at 9:22 P.M.					
	severe pain wh	nen T & R (moaning,					
	crying out, tearin	g at clothing)5/15/11 at					
	7:30 P.Munco	omfortable when T &					
	R5/16/11 at 2:5	50 P.MRoutine pain					
	meds as ord. (ord	lered), during					
	repositioning after	er lunch res. pulled up in					
	bed, yelling out,	"My leg, No No," was					
	given PRN med	at 12:30 with lunch then					
	routine pain med	s at 1400 (2:00 P.M.) et					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	LDING	NSTRUCTION 00	(X3) DATE : COMPL 05/24/2	ETED
	PROVIDER OR SUPPLIEI		 STREET A	ADDRESS, CITY, STATE, ZIP CODE DODIES LANE EN, IN46506		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	incont. (inconting repositioning secomfortable5/Yelling out we Notes lacked does the physician has ongoing pain.  During interview 5/17/11 at 9:10 A was having pain unable to rate he scale. The MAR had been given to A.M.  Nurse's Notes in P.MYells out 9:45 P.MResid any movement  The Director of indicated in an in 11:15 A.M., a Plobtained for Mo fast-acting pain administered every breakthrough pa wasn't controlling using the PRN Very doing the job. We the morphine to	emed much more 17/11 at 2:00 A.M. ith pain" The Nurse's cumentation to indicate d been notified of the  w with Resident #40 on A.M., she indicated she in her right hip, but was er pain on the 0-10 pain indicated a Norco 5 mg. o Resident #40 at 6:00  dicated, "5/17/11 at 3:45 when moved5/17/11 at ent has lots of pain with				

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155474		(X2) MU  A. BUILI  B. WING	DING	NSTRUCTION  00	(X3) DATE COMPI 05/24/2	LETED	
	PROVIDER OR SUPPLIER		p. wire	STREET A	DODIES LANE N, IN46506	<b>I</b>	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	I	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO	BE	(X5) COMPLETION
TAG	minutes to see ho	bw she does."		TAG	DEFICIENCY)		DATE
	5/18/11 at 11:35 D.O.N. were obsincontinence caracross the bed, gright femur (larg Resident #40 tov D.O.N. pushed of to aid in turning Resident #40 moscream out in particular and Chaptoviding incont #40 on 5/19/11 at moaned when the lowered to a flat out in pain when Resident #40 was oshe could be win pain as she was reached across the Resident #40's ripushed on her rigonto the left hipout in pain and y  During interview 5/19/11 at 1:35 Fewanted to controdid not want to "	e. CNA #15 reached rabbed Resident #40's e thigh bone) and pulled wards her while the n Resident #40's right hip her onto her left hip.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155474			LDING	NSTRUCTION  00	(X3) DATE COMPI 05/24/2	LETED	
	PROVIDER OR SUPPLIER		•	316 WO	DDRESS, CITY, STATE, ZIP CODE ODDIES LANE N, IN46506	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	was going to cor physician to eval	D.O.N. indicated she sult a "palliative care" luate Resident #40 and t to control her pain.					
	indicated, "Probl Resident Fall. Go complications ar fracture. Approa medication as or effectiveness and not getting relief	are Plan, dated 5/10/11, em: Fracture: Right Hip oal: Resident will have no ad minimal pain from hip ch:Administer pain dered and check for d notify doctor if resident"					
	5/18/11 at 8:50 indicated diagno	a.m. The resident's record ses of, but not limited to; scular accident, dementia,					
	January 9th, 201 February 9th, 20 March 6th, 2011 pounds. April 20 and May 2011 w resident's reweig at 126.9 pounds.	reights for the month of 1 was 141 pounds. 11's weight was 155.2. weight was 156.7 011 weight was 155.5, reight was 128.5. The ht for May was recorded The weight loss 6 pounds lost from April					
	lacked document	ted 4/17/11 to 5/15/2011, tation indicating the en notified of the					

	OF CORRECTION	X1) PROVIDER/SUPPLIFITED NUME		(X2) MU	LTIPLE CO	NSTRUCTION		(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	155474	JEA,	A. BUIL		00		05/24/2	
		100474		B. WINC				03/24/2	011
NAME OF I	PROVIDER OR SUPPLIER					DDRESS, CITY, STA	ATE, ZIP CODE		
BDEMEN	I HEALTH CARE CI	ENTED				ODIES LANE N, IN46506			
						11, 11140300			
(X4) ID		TATEMENT OF DEFICIEN		l .	ID		PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED  LSC IDENTIFYING INFO		'	PREFIX	CROSS-REFERENCE	/E ACTION SHOULD BE ED TO THE APPROPRIAT TICIENCY)	E	COMPLETION
TAG			ORMATION)		TAG	DEF	ICIENCT)		DATE
	significant weigh	it loss for May.							
	Resident Meal Ir April 2011, indic 15th, the residen and also the alter record lacked do	orm titled "Individentake Record," date atted from April 9th thad refused her somete. The resident cumentation to induce physician had be	ed h to the upper 's licate						
	On April 28th the # 54 refused all the April meal intakentire month of Athan 25% with remeals and alternative.	e form indicated R hree meals that day e form indicated for April, her intake was efusal of many of the ates. The nurses not ion to indicate the	y. The or the as less he						
	physician or the notified.	dietitian had been							
	3/15/10, indicate weight loss (Mar more uneaten more choking Dx (diag Dx: Dysphagia	lan of care, dated d "Problem: Significh 2010) Leaves 2 ost meals, at risk for gnosis) Hiatal Hern Approach:Notify ficant weight chan	25% or or nia, y RD						
	Nursing on 5/19/	iew with the Direc /11 at 5:20 p.m. reg	garding						
	the lack of the physician being notified of								
	the significant weight loss, she indicated								
	she was not awar	re he was not notif	ied or						
FORM CMS-2	.567(02-99) Previous Version	ons Obsolete	Event ID: 4E	ZC11	Facility I	D: 000506	If continuation sh	neet Pa	ge 11 of 162

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		Ì	LDING	NSTRUCTION  00	(X3) DATE COMPI 05/24/2	LETED	
	PROVIDER OR SUPPLIEF		•	316 WO	DDRESS, CITY, STATE, ZIP CODE DODIES LANE N, IN46506	•	
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	BE	(X5) COMPLETION
TAG	why he was not	notified, but indicated he made aware right away.		TAG	DEFICIENCY)		DATE
	Nutritional Prob Change," dated I Notify and const regarding patien	titled "Nutritional Risk, lem and/or Significant 10/31/10, indicated "7. alt with physician t's current nutritional ant change in nutritional					
	5-16-2011 at 10: diagnoses includ	s record was reviewed on 15 a.m. Resident #27's e, but were not limited to, driplegia, dysphagia, and					
	was observed du	oxygen at 4 liters via a					
	#7, RN #8 and the Director of Nurse providing care to	6:11 p.m., RN # 6, RN ne ADON (Assistant ing) were observed o Resident # 27. Once ted, all the staff except ne room.					
	was noted inside the tracheotomy to lift the sheet to	large amount of mucus of the outer cannula of The ADON was asked o allow observation of the ent #27's nail beds were					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE S COMPL		
		155474	A. BUI B. WIN	LDING IG		05/24/2	011
			D. WII		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF F	PROVIDER OR SUPPLIER			316 WC	OODIES LANE		
	NHEALTH CARE CE			ļ	EN, IN46506		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
1710		r and the fingers were		mo			DATE
		olor. Resident #27 was					
	1 *	experiencing a violent					
		r lumen of the oxygen					
	_	to be completely					
	obstructed with r	• •					
		I #8 was requested to					
	_	n with a biox (to test					
		vels), Resident # 27's biox					
	was 84%.	),					
		#8 brought suction					
	_	om. Resident #27					
	observed coughing						
		sident #27's biox is 87%,					
	_	tions visualized, Resident					
	#27 was observed	d gagging.					
	At 6:57 p.m., The	e biox was 86%, mucus					
	was observed gu	rgling from resident's					
	mouth.						
	At 7:11 p.m., Su	ction equipment brought					
	to Resident #27's	room and was coughing					
	violently, gaggin	g, and flailing forward in					
	bed. Biox was 8	9%. RN #8 indicated					
	that he does not l	know this man, and he					
	I -	this floor for a couple of					
	weeks.						
	_	ox up to 89%, DON now					
		n. Requested different					
	biox to compare						
	_	fferent biox brought to					
	1	27's biox was then 93%.					
	Resident was the						
	repositioned in b	ed.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		INSTRUCTION 00	(X3) DATE S COMPL		
		155474	B. WIN			05/24/2	011
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	1	ADDRESS, CITY, STATE, ZIP CODE	•	
BDEMEN	N HEALTH CARE CE	ENTED		1	OODIES LANE EN, IN46506		
					IN, IN <del>1</del> 0500		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	A review of the "	Comprehensive Care					
	Plan Report" ind	icated that					
	"ProblemAt 1	risk for respiratory					
		Will have no or minimal					
		ressApproachOxygen					
		tor & report s/sx (signs					
		of shortness of breath,					
		g and/or cyanosis (lack of e oxygen saturation as					
	1 20 //	sessment as ordered and					
		suction as neededKeep					
		mily informed as					
	needed"	<i>u</i>					
	The "Treatment I	Record" for May of 2011					
	stated, "Oxyger	n to trach (tracheotomy)					
		oxygen saturation 90%					
	or greater"						
	771 UN ( 1' /'	D 10 1 / 134 2011					
		Record" dated May 2011					
	needed"	action oral cavity as					
	necucu						
	The "Medication	Record" dated May 2011					
		action trach prn (as					
	1	ease secretions"					
		Record" dated May 2011					
	· · · · · · · · · · · · · · · · · · ·	ygen) to trach to keep					
	O2 saturation gre	eater than 90%"					
	On 5/17/11 -4.7	DN #0 indicated					
	_	o.m., RN #8 indicated 7 experienced a decline in					
		ion on 5/16/11 from 6:11					
	respiratory functi	1011 011 3/ 10/ 11 HOIII U. 11					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155474	B. WIN			05/24/2	011
		<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF	PROVIDER OR SUPPLIEF	₹			OODIES LANE		
BREMEN	N HEALTH CARE C	ENTER			EN, IN46506		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	p.m. until 7:18 p	.m. RN #8 indicated a					
	respiratory asses	sment was not completed					
	prior to suctionii	ng or immediately after					
	1 ^	staff to determine lung					
	1	RN #8 also indicated					
	uie physician sno	ould have been notified.					
		record was reviewed on					
	5-19-2011 at 2:0	0 p.m. Resident #3's					
	diagnoses includ	le, but were not limited to,					
	Diabetes Mellitu	s and dementia.					
	The "Medication	Record" for the month					
		"Sliding scale, if blood					
		units, 151-200= 3 units,					
	"						
		s, 251-300= 9 units,					
		its, 351-400= 14 units,					
		l sugar less than 60 or					
	greater than 400	"					
	The "Medication	n Record" on 3/26/11 at 4					
	p.m., indicated	the blood sugar was 483.					
	_	cumentation supporting					
	that MD was not	**					
	mat wid was not	illed.					
	The "Medication	n Record" on 3/27/11 at 4					
	_	he blood sugar was 420.					
	There was no documentation supporting						
	that MD was notified.						
	An interview was conducted on 5/19/2011						
	at 4:25 p.m., with LPN #3. LPN #3						
	_	nen an MD is notified the					
		ss Notes would be					
	1 1 10 Bracht 1 10 Bro	33 1 3 100 11 3 11 3 11 3 11 3 11 3 11					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		A. BUI	LDING	NSTRUCTION 00	CON	TE SURVEY MPLETED 4/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CO ODIES LANE N, IN46506		2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	regarding the blo	3 looked for notification od sugars on 3/26/11 and unable to find any					
	10/31/07 was rev p.m. stated, "St consults with the and notifies the r when:A signifi- resident's physica statusCompliar family has design receive calls, tha when notification	"Notification" dated riewed on 5/24/11 at 2:00 raff informs the resident, ir attending physician, esident's surrogates cant change occurs in the rail, mental, psychosocial rice Guidelines2. If the rated a member to the individual is notified rice are required, unless competent resident's					
	reviewed on 5/16 indicated diagnost diabetes mellitus and peripheral new A Physician Orderindicated, "GludailySliding Science 60-150=0 units, 201-250=8 units,	er, dated 2/5/11, cometers twice cale. If blood sugar					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL		
		155474	B. WIN			05/24/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	•	
	HEALTH CARE C			<u> </u>	N, IN46506		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	MD if blood sugathan 350"	ar less than 60 or greater					
	man 330						
	Review of the Fe	ebruary 2011, MAR					
	`	ninistration Record)					
	-	ent # 80's blood sugar on					
		(4:00 P.M.) was 368.					
	Review of the Ap	00 blood sugar on 4/3/11					
	was 356.	00 0100d sugai 011 4/3/11					
	Review of the cli	inical record lacked					
	documentation o	f doctor notification.					
	Resident # 80's C	Care Plan, dated 5/19/11,					
	indicated, "Kee as needed"	ep Physicianinformed					
	Interview on 5/20	0/11 at 9:15 A.M., the					
	`	t Director of Nursing)					
		vsician should have been					
	notified of the ab	ove blood sugar results.					
	A facility policy	titled "Notifications,"					
	revised 10/31/10						
		s with their attending					
	^ *	a significant change					
		dent's physical, mental or					
	be altered signifi	usTreatment needs to					
	be altered signiff	Cantry					
	3.1-5(a)(2)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155474 05/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 316 WOODIES LANE BREMEN HEALTH CARE CENTER BREMEN, IN46506 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE A resident has the right to prompt efforts by F0166 the facility to resolve grievances the resident SS=D may have, including those with respect to the behavior of other residents. F0166 F-166 It is the practice of this 06/23/2011 Based on observations, interviews and facility to ensure the highest record review, the facility failed to ensure quality of care is afforded our grievances had been addressed related to residents. Consistent with this odors, dirty and cluttered halls for 2 of 2 practice, the following has been grievance's filed by 1 of 1 resident family done: The corrective action taken for the residents found to have in a supplemental sample of 30. been affected by the deficient practice was: The family of Resident # 52. resident #52 and members of the Resident Council were notified of action steps taken to resolve the Findings include: grievance surrounding odor on 6/14/11. The corrective action 1. Review of the facility grievance records taken for those residents having on 5/18/11 at 2:45 p.m., indicated the the potential to be affected by the same deficient practice is:All following grievance was expressed by grievances received in the last 30 Resident # 52's family on 10/8/10. The days have been reviewed for grievance indicated "...strong urine smell appropriate resolution and in MDR (main dining room)...floors in follow-up. Any unresolved issues have had additional steps taken hallways dirty...." to ensure satisfaction and resolution to any voiced Resident # 52's record was reviewed on concerns. The measures put into 5/24/11 at 11:00 a.m. The resident's place and a systemic change record indicated diagnoses of, but not made to ensure the deficient practice does not recur is: Facility limited to;'s Alzheimer's disease, diabetes, staff has been in-serviced on the cardiac dysrhythmias, and urinary grievance procedure and follow incontinence. up when a resident or family member has a concern. All staff was in-serviced on the location of During a tour of the facility's north and the grievance forms. To ensure south dining rooms on May 16th 2011 at the deficient practice does not 6:00 p.m., a urine odor was detected in recur, the monitoring system both dining areas. There was a strong established is:A Performance Improvement indicator has been

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155474 05/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 316 WOODIES LANE BREMEN HEALTH CARE CENTER BREMEN, IN46506 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE urine odor throughout the facility the established which evaluates compliance with the grievance entire day from 6:30 a.m. until 9:00 p.m. process. Executive Director or The halls on the north and south areas of designee will complete the the facility were observed to be cluttered indicator weekly for the first month, monthly for the first with bedside tables, Hoyer lifts, trash quarter and quarterly thereafter barrels, housekeeping supplies, and with results forwarded to the walkers. The wheelchairs were lined up facility performance improvement all along the side of the halls on both committee for further evaluation units, north and south. Medication carts or resolution. POC Date: 6/23/11 were observed along the halls amongst the other items on both units. The hall floors were observed to be soiled with dirt debris. During a group meeting on 5/17/11 at 10:30 a.m., with 10 alert and oriented residents, they all complained of the hallways in the facility being cluttered impeding their wheelchair mobility at times. Observation was made on 5/18/11 at 7:10 a.m., of a resident having trouble maneuvering his wheelchair down the hall when other residents pass by due to the hall clutter. Review of another grievance reported by Resident # 52's family dated 2/1/11 indicated "...says smell is horrible (eyes burn when visiting d/t (due to) urine smell so bad) says (name) stated "this will never happen" says husband (name) doesn't even want to come d/t "it's horrible here."

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4EZC11

Facility ID:

000506

If continuation sheet

Page 19 of 162

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	COM	TE SURVEY  IPLETED  1/2011	
	PROVIDER OR SUPPLIER		<b>F</b>	STREET A	DDRESS, CITY, STATE, ZIP ODIES LANE N, IN46506	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	1	re not getting good care, at is going on here"					
	indicated the follogrievance; "Spokethe nurse in MD keep a closer eye the dining room.	eport, dated 10/8/10, lowing to resolve the see with (name) who was R (main dining room) to e on what is happening in Spoke with (name) about end manager add to Oct ng meeting."					
	1	esolution documented for adicated "Hallways be floor tech."					
	a.m., with a fami to remain anony the urine smell in indicated it was remove both mat rid of the urine of	iew on 5/18/11 at 10:30 ily member who wished mous, complained about in her mother's room. She so strong they had to ttresses in the room to get odor. She also indicated smelled of body odors.					
	regarding the structure throughout the factorial not smell to the strong urine	on 5/18/11 at 11:45 a.m., ong urine odors acility, he indicated he chem.  odor was present acility on the following					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED
		155474	B. WING		05/24/2011
	PROVIDER OR SUPPLIER		316 W	TADDRESS, CITY, STATE, ZIP CODE VOODIES LANE MEN, IN46506	
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	ID	·	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
F0221 SS=D	May 17th from 8 May 18th from 6 May 19th from 8 May 20th from 8 and May 23rd from 8  The facility's pol "Complaints/Gric indicated "12.0 up to validate res the resident and to member/respons with the resolution  3.1-7(a)(2) The resident has to physical restraints discipline or convet treat the resident's Based on observative record review, the a resident was ke related to the fact restraint to keep moving about the	evance" dated 10/31/10 Conduct on-going follow solution is maintained and family lible party's are satisfied on"  The right to be free from any imposed for purposes of enience, and not required to a medical symptoms. Pation, interview, and the facility failed to ensure expt free from restraints ility using a recliner as a the resident from freely the facility for 1 of 1 and for restraints in a	F0221	F-221 It is the practice of this facility to ensure the highest quality of care is afforded ou residents. Consistent with the practice, the following has be done: The corrective action of for the residents found to has been affected by the deficient practice was: Resident has a ongoing and long term prefect to use the recliner for periodic rest and night time sleeping. The resident was completed for resident #35. plan of care was updated to	r nis een taken ve nt n rence s of A

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI	
		155474	B. WIN			05/24/2	:U 1 <sup>-</sup> 1
NAME OF 1	PROVIDER OR SUPPLIER	8		1	ADDRESS, CITY, STATE, ZIP CODE		
DDEMEN	LUEALTHOADEO	ENTED		1	OODIES LANE		
BREME	N HEALTH CARE C	ENIER		BREME	EN, IN46506		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	reflect the presence of the		DATE
	D :1				recliner as a restraint. The		
		linical record was			corrective action taken for the	nose	
		9/11 at 10:45 A.M., and			residents having the potenti	al to	
	1	ses of, but not limited to:			be affected by the same det		
		entia with behavioral			practice is:A facility wide au		
	1	olar disorder, and			was conducted to evaluate a assistive devices currently in		
		der. Resident #35 was			place to ensure that any oth		
	admitted to the f	acility on 11/22/10.			potential restraints have been		
					identified, assessed and car	е	
	1	ur of the facility on			planned as needed. The measures put into place and	1 2	
	5/16/11 at 7:00 A	A.M., while accompanied			systemic change made to e		
	by LPN #2, she	indicated Resident #35			the deficient practice does r		
	had behaviors, w	vas confused, and was a			recur is:Nursing staff has be	en	
	two person assis	t. He was observed sitting			in-serviced on resident		
	in a recliner in the	ne central living area of			positioning, the definition of restraint and appropriate	а	
	the dementia uni	t. The recliner was tipped			assessment completion. To	)	
	back and the foo	trest was fully extended			ensure the deficient practice		
	out. Resident #3	55's feet dangled off to the			not recur, the monitoring sy		
	side.				established is:A Performand		
					Improvement indicator has I established which evaluates		
	Resident #35 wa	s again observed on			compliance with restraints a		
	5/16/11 at 11:55	A.M., sitting in the same			assessing for restraints. Th		
	recliner in the ce	entral living area of the			Director of Nursing or desig		
	dementia unit. H	is recliner was tipped			will complete indicator week the first month, monthly for the	-	
	back with the fo	otrests fully extended and			first quarter and quarterly		
	his legs dangling	g off to the left side. He			thereafter with results forwa	rded	
	was leaning forv	vard and attempting to			to the facility performance		
	rise from the cha	ir, but was unsuccessful			improvement committee for further evaluation or		
		ositioning of the recliner.			resolution. POC Date: 6/23/	11	
	_	were wet, as he was					
	_	large amount of urine.					
		-					
	During interview	with the Social					
	_	on 5/16/11 at 11:58					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	155474	A. BUI		00	05/24/2	
		100474	B. WIN		ADDRESS CITY STATE TIN CODE	00/24/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
BREMEN	N HEALTH CARE CE	ENTER		1	EN, IN46506		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	NIE.	DATE
	P.M., she indicat	ed meals would be					
	arriving and she	would ensure Resident					
	#35 would be cle	aned up for lunch. CNA					
	#5 and LPN #2 w	vere observed assisting					
	Resident #35 to t	he bathroom five					
	minutes later and	I changed his clothing.					
	Resident #35 was	s observed later that day					
		he same recliner in the					
	·	e was, again, trying to					
	_	liner and was unable to					
		the elevated footrest and					
		of the chair. Other					
	_	rea were engaged in					
		~ ~					
	· ·	sident #35 did not appear					
	interested in the c	ongoing activities.					
	On 5/18/11 at 4:2	25 P.M., Resident #35					
	was observed in	the recliner in the central					
	living area of the	dementia unit. The					
	recliner was tippe	ed back with the footrest					
	fully extended. H	Ie had his socks and					
	shoes off and his	bare feet dangled off to					
	the left side of th	e footrest. He was					
	attempting to put	a rolled up magazine					
	into one of the so	ocks he had removed. His					
	pants were soiled	l with urine.					
	During interview	with Coolal					
	During interview						
		on 5/18/11 at 4:40 P.M.,					
		sident #35 needed					
	supervision beca	use of his behaviors.					
	Review of Reside	ent #35's quarterly MDS					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155474		(X2) MULT A. BUILDIN		NSTRUCTION  00	(X3) DATE S COMPL	ETED	
		155474	B. WING			05/24/2	U11
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
BREMEN	N HEALTH CARE CE	ENTER			ODIES LANE N, IN46506		
(X4) ID		TATEMENT OF DEFICIENCIES		D I	,		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	1	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	T	AG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	(Minimum Data	Set) Assessment, dated					
	4/06/11, indicated	d he was ambulatory with					
	one person assist	•					
	The Director of N	Junging indicated in an					
		Nursing indicated in an 9/11 at 5:00 P.M., the					
		using the recliner as a					
	l *	re, a care plan was not in					
	· ·	OS Assessment did not					
	1 ^	t #35 had a restraint.					
	1	titled "Restraints,"					
	· ·	indicated, "Policy: The					
		ight to be free from any					
	_ :	ical restraints imposed					
	for the purposes	_					
	resident's medica	I not required to treat the					
		ical Restraints: Any					
	1	or physical or mechanical					
		or equipment attached or					
		esident's body that the					
		t remove easily which					
	restricts freedom	of movement1.					
	Physical restraint	ts include, but are not					
		lacing a resident in a					
		ts a resident from					
	rising"						
	3.1-3(w)						
F0241	` ′	romote care for residents in					
SS=E	a manner and in a	n environment that					
		nces each resident's dignity recognition of his or her					
	individuality.	Toogrition of the Of the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155474 05/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 316 WOODIES LANE BREMEN HEALTH CARE CENTER BREMEN, IN46506 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Based on observations, interviews, and F0241 F-241 It is the practice of this 06/23/2011 facility to ensure the highest record review, the facility failed to ensure quality of care is afforded our residents' dignity related to: urinary residents. Consistent with this incontinence (Residents: #35, #49, #3), practice, the following has been display of red biohazard barrels in a done: The corrective action taken for the residents found to have resident's room (Resident #87), and been affected by the deficient residents with facial hair (Residents: #20, practice was: Residents #20, #51 #51, #58, #60), and residents left sitting and #58 facial hair grooming idle and unengaged in the hallway of the issues were resolved during the course of the survey. Resident south unit(Resident #91, #59, #75, #70, #60's preferences related to #85, #54, #53, #68, #69, #55, #84) and in retaining facial hair will be the North Unit lounge (Residents #7, #17, honored. The red barrels in the #21, #12, #8, #3, #32, #9, #6, and # room of resident #87 were removed during the survey and 18.) This deficient practice affected 4 of offered an apology. Residents 19 in the sample of 19 and 24 of 30 in the #3, #35, and #49 were provided supplemental sample of 30 reviewed for incontinence care and wheel dignified care. chairs and cushions cleaned during the course of the survey. Residents #91, #59, Findings include: #75, #70, #85, #54, #53, #68, #69, #55, #84, #7, #17, #21, #12, 1. Resident #35's clinical record was #8, #3, #32, #9, #6 and #18 were reviewed on 5/19/11 at 10:45 A.M., re-evaluated related to functional status and participation in activity indicated diagnoses of, but not limited to: programming. The corrective Alzheimer's dementia with behavioral action taken for those residents disturbance, bipolar disorder, and having the potential to be affected by the same deficient practice delusional disorder. is:The facility validated that residents are free of unwanted During initial tour of the facility on facial hair. All rooms were 5/16/11 at 7:00 A.M., while accompanied audited for unnecessary medical equipment and items removed as by LPN #2, she indicated Resident #35 needed. All residents are being had behaviors, was confused, incontinent, monitored for appropriate and and a two person assist. timely incontinence care to prevent personal hygiene from being compromised and/or Resident #35 was observed on 5/16/11 at

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	TED
		155474	B. WIN			05/24/20 <sup>-</sup>	11
			B. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			OODIES LANE		
BREMEN	N HEALTH CARE C	ENTER		1	EN, IN46506		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ng in a recliner in the			equipment becoming soiled.	All	
	central living are	ea of the dementia unit.			residents in the center were evaluated related to function	al	
	His sweat pants	were wet, indicating he			status and activity programm		
	was incontinent	of a large amount of			modified to enhance offering		
	urine.				all functional levels. The		
	0,2 0,1				measures put into place and	а	
	During observati	ion of a medication			systemic change made to en		
	1				the deficient practice does no	I .	
	_	ass on 5/16/11 at 5:20			recur is:Nursing staff has be		
		ndicated Resident #35			in-serviced related to groomi provision of incontinence car	<u> </u>	
		oom. She opened the door			and storage of isolation	c,	
		which was located			equipment. Activity Director	has	
	immediately off	of the dining room. Two			been in-serviced related to		
	visitors had full	view of the bathroom			enhance programming for al	ı	
	commode on wh	ich Resident #35 was			functional levels. To ensure		
	seated with his p	ants down.			deficient practice does not re	ecur,	
	·				the monitoring system	_	
	On 5/18/11 at 4:	25 P.M., Resident #35			established is:A Performance Improvement indicator has b	-	
		the recliner in the central			established which evaluates		
					compliance with grooming/fa	cial	
	_	e dementia unit. He had			hair, incontinence care, pers		
		oes off and his bare feet			device cleanliness, rooms fre	ee	
	_	e left side of the footrest.			from unnecessary	.	
	His pants were s	oiled with urine.			medical/storage equipment a	and	
					activity programming for dependent residents. The		
	During interview	with Social			Director of Nursing or design	iee	
	Service/Director	on 5/18/11 at 4:35 P.M.,			will complete indicator weekl		
		e could not toilet Resident			the first month, monthly for the	· .	
		nd the other staff person			first quarter and quarterly		
	was busy with of				thereafter with results forwar	ded	
	as sasy with or	Tolidollio.			to the facility performance improvement committee for		
	2 During initial	tour of the domantic unit			further evaluation or		
	1	tour of the dementia unit			resolution. POC Date: 6/23/1	<sub>I1</sub>	
	on 5/16/11 at 7:00 A.M., while being			221111111111111111111111111111111111111			
		LPN #2, Resident #49					
		her room. She was					
	identified as being	ng incontinent. She night					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155474	B. WIN			05/24/2	011
		1	P		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹		1	OODIES LANE		
BREMEN	N HEALTH CARE C	ENTER		1	EN, IN46506		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re l	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	clothes and all o	f her bed linens were					
	urine soaked, at	the time, and CNA #5					
	1	ent #49 was to be					
		#5 was observed					
		ent #49 for her shower at					
	7:40 A.M.	in in in including wer at					
	7.40 A.WI.						
	Resident #49 wa	s observed seated at the					
		le on 5/16/11 at 11:45					
	1	rine odor surrounded her.					
	1	N #2 assisted her to the					
		lacks had a large wet area					
	1	_					
	1	indicating she had been					
	incontinent of a	large amount of urine.					
	LPN #2 indicate	d in an interview on					
		A.M., that many of the					
	1	unit were incontinent and					
		e with toileting. She					
	1	there was a limited					
		on the unit and it made it					
	1 -	de the necessary care for					
	residents requiri	ng two person assist.					
	3 Resident #3's	clinical record was					
		9/11 at 2:00 P.M. and					
		ses of, but not limited to:					
	1						
	1	y of right femur fracture,					
	depression, and	consupation.					
	Resident #3 was	observed sitting in her					
	wheel chair across from the nurse's station						
		5/16/11. She smelled of a					
		r. The odor was brought					
	I sublig utilie 000	1. THE OUDT WAS DIVUGIIL					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPLI		
155474			B. WIN			05/24/20	011
	PROVIDER OR SUPPLIER		<u> </u>	316 WC	ADDRESS, CITY, STATE, ZIP CODE DODIES LANE EN, IN46506	•	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	DATE
	to the attention o	f CNA #30 who	Ī			i	
	immediately tool	Resident #3 to her					
	room.						
	CNA #30 and LF	N #25 were observed					
	transferring Resi	dent #3 to her bed via a					
	mechanical lift a	t 4:20 P.M. (5/16/11).					
	Resident #3's sla	cks were wet with urine					
		nce brief was dry upon					
	_	rther investigation of the					
		dicated a large pool of					
		the pressure reducing					
		heel chair. The top and					
		shion were wet with					
	urine.						
	D	'.1 I DNI //271					
	_	with LPN #25, at the					
		vation, she indicated staff					
		perly clean the wheel					
	*	ling her with previous					
	incontinence care	₹.					
	5 Resident # 20'	s record was reviewed on					
		.m. The record indicated					
	diagnoses of, but						
	-	ase, hypertension, and					
	depressive disord						
	•						
	During a tour of	the facility on 5/16/11 at					
	7:00 a.m. Reside	nt # 20 was observed up					
		face was observed to					
	have several day	s of facial hair growth.					
	Resident # 20's p	lan of care updated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE S COMPL	
		155474	A. BUI B. WIN	LDING IG		05/24/2	
NAME OF I	PROVIDER OR SUPPLIEI	<b>  </b> 			ADDRESS, CITY, STATE, ZIP CODE		
				1	OODIES LANE		
	N HEALTH CARE C				N, IN46506		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES  NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
	5/10/11 indicate	d "Discharge not feasible					
	related to;dem	nentia, unable to care for					
	selfApproach	provide care and services					
	1 -	sident's record lacked a					
	care plan specifi	c for grooming needs.					
	During an interes	riew at that time with the					
		nt Director of Nursing)					
	`	e resident could do much					
		needed cueing at times.					
		e resident was very					
	confused and wa	as a wander risk.					
	C D :1						
		's record was reviewed on					
	_	o.m. The resident's record					
	·	ses of, but not limited to;					
		ailure, peripheral vascular nsion, and depression.					
	disease, hyperter	nsion, and depression.					
	During a tour of	the dining room on					
	5/16/11 at 8:30 a	a.m., an observation was					
		nt # 51 sitting at a dining					
		residents. Observation					
		chin covered with a					
	heavy growth of	gray hairs.					
	The Resident's o	uarterly MDS (minimum					
		nent, dated 4/11/11,					
	<b>1</b>	ident required extensive					
		wo staff assistance with					
	personal hygiene	2.					
	The media of a						
	_	an of care, dated 5/16/11,					
	maicaled " Prob	lem; Requires physical					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
155474		B. WIN			05/24/2	011	
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEI	₹			OODIES LANE		
BREMEN	N HEALTH CARE C	ENTER		1	EN, IN46506		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	<b>+</b>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	assist of staff for	ADL's (activities of daily					
	living)" The	Resident's plan of care					
	failed to indicate	e to keep her face free					
	from chin hair.	•					
	7 Resident # 60	's record was reviewed on					
	_	o.m. The Resident's record					
	1	eses of, but not limited to;					
	1	ocephalus; mental					
		ension, impaired renal					
	function, and ob	sessive compulsive					
	disorder.						
	During a tour of	the dining room on					
	5/16/11 at 8:30 a	a.m., an observation was					
		nt # 60 sitting at a dining					
		residents. Observation					
		resident to have a large					
		_					
		hair. Long curly hairs					
	_	d on her chin was					
	observed.						
	The Resident's p	lan of care, updated					
	3/8/11, indicated	l "Problem: Alert and					
	oriented with inc	creased forgetfulness and					
		ng reminders and					
		are plan, dated 3/2/11,					
		lem; discharge not					
		ach indicated to provide					
		-					
	care and services	S uarry.					
	A form titled "C	are Plan Conference					
	1	d 3/8/11, indicated "Plan					
	of Care: Nursing	g: Supervision ADL's. The					

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU	LTIPLE CO	NSTRUCTION		(X3) DATE S COMPL	
AND PLAN	OF CURRECTION	155474	EK;	A. BUILI	DING	00		05/24/2	
		100474		B. WING				03/24/2	011
NAME OF I	PROVIDER OR SUPPLIER					DDRESS, CITY, STA	ATE, ZIP CODE		
RREMEN	N HEALTH CARE CI	ENTER				ODIES LANE N, IN46506			
(X4) ID PREFIX		TATEMENT OF DEFICIENC CY MUST BE PERCEDED I		D D	ID PREFIX		PLAN OF CORRECTION VE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFOR		'	TAG	CROSS-REFERENC DEI	ED TO THE APPROPRIAT FICIENCY)	E	DATE
		l lacked a plan of ca			_				
		ng and grooming ne							
		ing und grooming no							
	8. Resident # 58'	s record was review	ved on						
		a.m. The resident's							
		diagnoses of, but no							
		ntia with behaviors,							
		rosis, kyphosis and	•						
	seborrhea derma								
	During a tour of	the dining room on							
	1	.m. an observation							
		t # 58 sitting at a tal							
		nt's. Resident # 58 v							
		long curly facial ha							
	her upper lip and								
	Trans								
	Review of Resid	ent # 58's quarterly	MDS						
		d 5/2/11, indicated s							
	· ·	ssistance with one s							
	assistance for hy	giene and bathing.							
	The resident's pl	lan of care dated 2/7	7/11,						
	_	res physical assist v							
	1 *	ch: Set up equipmen							
		d provide cues for u							
	1	st after she has tried							
	The facility's pol	icy and procedure t	itled						
	• • •	dated 10/31/10 ind							
	"Policy: Care is 1	provided in a manne	er and						
	'	nt that maintains or							
	enhances each pa	atient's dignity and							
	_	cognition of his or h	ner						
FORM CMS-2	2567(02-99) Previous Version			ZC11	Facility I	D: 000506	If continuation sh	neet Par	ge 31 of 162

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155474		(X2) M A. BUI		NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		B. WIN			05/24/2	011	
	PROVIDER OR SUPPLIER		•	316 WC	ADDRESS, CITY, STATE, ZIP CODE	•	
BREMEN	N HEALTH CARE CE	ENTER		BREME	N, IN46506		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	individuality2. as they wish to be combed and style shaved/trimmed,	The patient is groomed e groomed (e.g., hair					
	reviewed on 5/19	ses of, but not limited to, il cord disease,					
	5/16/11 at 2:45 P biohazard barrels resident's room a the roommate. R was taken off iso	with Resident # 87 on .M., two 50 gallon red were present in the the foot of the bed of esident # 87's Roommate lation precautions on onger had a need for the					
		vere observed in the room 0 P.M. and 3:50 P.M., t 3:40 P.M.					
	Resident # 87 inc (Resident # 88) v when he was adn further indicated the red barrels in	8/11 at 2:30 P.M., licated his roommate was already in the room nitted on 2/24/11. He he asked the staff what the room were for. He ff told him they were for					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì		INSTRUCTION 00	(X3) DATE S COMPL		
1111212111	or conditions	155474	A. BUII B. WIN			05/24/2	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				316 WC	OODIES LANE		
BREMEN	NHEALTH CARE CE	ENTER		BREME	EN, IN46506		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
1710	some type of infe	· · · · · · · · · · · · · · · · · · ·	+	1710	•		DATE
		oction.					
	RN # 20 on 5/19/	/11 at 4:10 P.M.,					
	indicated she the	red barrels in Room					
	(number) were fo	or Resident # 87, but she					
	was unsure what	these were for.					
	Interview with I	PN # 9 on 5/20/11 at 9:45					
		ted the red barrels in					
	l '	were originally for					
	` ′	it were now for Resident					
	l '	on of Room (number) on					
		A.M., the red barrels were					
		l in the room. Resident #					
	_	red barrels were just					
	removed from the	5					
	Temoved from the	C 100III.					
	9. On 5/18/2011	at 4:40 p.m., eleven					
	residents (Reside	ent #91, 59, 75, 70, 85,					
	54, 53, 68, 69, 55	5, 84) on the South Unit					
	were observed si	tting in the hall in					
	wheelchairs again	nst the wall facing the					
	South Nursing St	tation and not engaged in					
	any type of activi	ity or conversation.					
	An intomic	a conducted on 5/10/11 -4					
		s conducted on 5/18/11 at					
	_	PN #3 indicating that the					
		d up waiting for their					
	dinner meal at 6:	10 p.III.					
	An interview was	s conducted on 5/18/11 at					
	5:04 p.m., with th	he Administrator					
	indicating the res	sidents are in front of the					
	nursing station si	nce they are a fall risk.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155474		ļ .	LDING	00	l` ′	e survey pleted /2011	
NAME OF PROVIDER OR SUPPLIER  BREMEN HEALTH CARE CENTER				316 WO	DDRESS, CITY, STATE, ZIP CODE OODIES LANE N, IN46506		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODE TO THE APPROPRIES OF THE APPROPRIES OF THE APPROVED	) BE	(X5) COMPLETION DATE
	5/16/2011 at 4:0 was made of 10 lounge adjacent Residents sitting were Residents 3, # 32, #9, # 6, a were in their who be in close proxi.  The television with the in the room. The engaged in watch of the residents wheads hanging downweelchairs.  Resident # 8 was Help." over and yelling, "Put me  Resident # 9 was go pee" over and go pee" over and go pee over and go	as observed with his body ght in his wheelchair. His oserved hanging over the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		(X2) MU A. BUIL B. WING	LDING	NSTRUCTION 00	(X3) DATE COMPI 05/24/2	LETED	
NAME OF PROVIDER OR SUPPLIER  BREMEN HEALTH CARE CENTER			•	316 WC	ADDRESS, CITY, STATE, ZIP CODE DODIES LANE EN, IN46506	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0248 SS=D	time, she indicated 6:00 p.m., and in would wait in this She indicated she else to do with the 3.1-3(a)  The facility must p program of activities accordance with the assessment, the ir mental, and psych resident.  Based on interview record review, the provide activities the individual resupractice affected for activities in a Resident: #27  Findings include Resident #27's resid	rovide for an ongoing es designed to meet, in ne comprehensive nterests and the physical, osocial well-being of each ew, observation, and e facility failed to a based on the needs of sidents. This deficient 1 of 9 resident reviewed sample of 19.	F0	248	F-248 It is the practice of thi facility to ensure the highest quality of care is afforded or residents. Consistent with the practice, the following has been affected by the deficient practice was: Resident #27 been reassessed related to functional level and his individualized plan of care the been updated to reflect enhance of the practice was: The correct action taken for those reside having the potential to be at by the same deficient practions in the center evaluated related to function status and activity programment modified to enhance offering all functional levels. The	tur his een taken ave nt has as anced ive ents ffected ce were nal ming	06/23/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4EZC11

Facility ID:

000506

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLET			COMPLETED			
155474			B. WIN			05/24/2011		
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER			1	OODIES LANE			
BREMEN	N HEALTH CARE CE	ENTER		1	EN, IN46506			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE		
	indicated that Re	sident #27 only gets up			measures put into place and	I		
	twice a week for	sensory group. RN #10			systemic change made to en			
	also verified that	there is no order stating			the deficient practice does no recur is:The Activity Director			
		only get up two times a			activity staff along with nursir			
	week.	5 & 1			staff has been in-serviced re			
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				to enhance programming for			
	On 5/17/11 at 0.1	15 a.m., Resident #27			functional levels. To ensure			
					deficient practice does not re	cur,		
		the TV lounge during			the monitoring system			
		No contact with Resident			established is:A Performance Improvement indicator has b			
	#27 was witnesse	ed during this session.			established which evaluates	3611		
					compliance with resident			
	On 5/20/11 at 3:1	15 p.m., RN #8 verified			involvement in activity			
	Resident #27 was	s only transferred out of			programming at all functiona			
	bed once from 5/	16/11 through 5/20/11			levels. The Executive Direct			
	for sensory group	<del>-</del>			designee will complete indicator			
					weekly for the first month,	1		
	The Comprehens	sive Care Plan Report			monthly for the first quarter a quarterly thereafter with resu			
	_	ed "Non-verbal-alert, but			forwarded to the facility			
		·			performance improvement			
	appears unaware				committee for further evaluat	ion		
		counding," updated			or resolution. POC Date: 6/2	3/11		
		ed, "Place by TV						
		nere he can be seen from						
	Nurses Station th	rough window"						
	The Comprehens	sive Care Plan Report						
		ed "d/t (due to) condition						
		staff for social and						
	1 1	nulation)" updated						
	I - '	ed, "involve in small						
		•						
	group at least 2x	· · · · · ·						
	I '	in lounge place where						
	1	ursingobserve for any						
	changes and doc	ument"						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155474	A. BUILDING B. WING		05/24/2011
NAME OF F	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
BREMEN	I HEALTH CARE CE	ENTER	<b>I</b>	OODIES LANE :N, IN46506	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
IAG		, "Activity Programs,"	IAG	DEFICIENCE)	DATE
		as reviewed on 5/24/11 at			
	-	, "A resident's interests			
	-	entified and a recreation			
	(Activity) progra	m designed to appeal to			
	his or her interest	ts and to enhance the			
	resident's highest	practicable level of			
		and psychosocial well			
	_	creation program occurs			
		at of each resident's			
	•	ssessment and care plan			
		individual resident's encesb. Care plans			
	-	n programs that are			
		ach resident based on the			
	** *	abilities, needs, and			
		e recreation program: b.			
	•	tion or solace;d. Care			
	plan address issu	es, concerns, problems,			
	or needs affecting	g the resident's			
	involvement/eng	agement in activities"			
	3.1-33(a)				
F0252 SS=E	comfortable and he allowing the reside personal belonging	rovide a safe, clean, omelike environment, ent to use his or her gs to the extent possible.			
		ations, interviews, and	F0252	F-252	06/23/2011
		e facility failed to ensure		It is the practice of this facility	y to
	an environment free of urine odors for 2 (Residents #3 and #49) of 12 residents			ensure the highest quality of	•
		continence in a sample of		is afforded our residents.  Consistent with this practice, following has been done: Th	
			-	<u> </u>	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155474 05/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 316 WOODIES LANE BREMEN HEALTH CARE CENTER BREMEN, IN46506 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 19 and hallway clutter on the North and corrective action taken for the residents found to have been South Units which had the potential to affected by the deficient practice affect all 79 residents residing on those was: The rooms of resident #3 units. and #49 were thoroughly cleaned per daily room cleaning policy. All unnecessary care equipment and Findings include: assistive devices have been removed from the hallways and 1. During initial tour of the dementia unit will only be stored on one side of on 5/16/11 at 7:00 A.M., while being the hall when not in use. The corrective action taken for those accompanied by LPN #2, Resident #49 residents having the potential to was identified as being incontinent. She be affected by the same deficient was urine soaked, at the time, and CNA practice is:All resident rooms #5 indicated she was getting ready to give have been audited and cleaned as necessary per daily room Resident #49 a shower. Resident #49's cleaning policy. No other room smelled with a strong, pungent, residents were found to have urine odor. CNA #5 was observed been affected by the deficient escorting Resident #49 for her shower at practice related to equipment storage. The measures put into 7:40 A.M. place and a systemic change made to ensure the deficient On 5/18/11 at 5:23 P.M., CNA #27 was practice does not recur is: observed providing incontinence care to Housekeeping staff has been Resident #49. Her room smelled from a in-serviced related to adherence to the deep clean schedule. All strong urine odor and permeated out into staff has been in-serviced related the hallway. to unnecessary equipment storage in the hall. To ensure the deficient practice does not recur, the monitoring system established is:A Performance Improvement indicator has been established which evaluates compliance with the daily room cleaning policy and proper equipment storage. The Executive Director or designee will complete indicator weekly for the first month, monthly for the

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474			LDING	NSTRUCTION  00	CON	TE SURVEY  MPLETED  1/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODI ODDIES LANE N, IN46506	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	2. During an observed at the south areas of the to be cluttered well and walkers. The up all along the swere observed to debris.	servation on the a strong urine odor was esident #3's room: .m. a.mmResident #3 not a.mm Resident #3 not a.mm Resident #3 not a.mm Resident #3 not			first quarter and quarter thereafter with results for to the facility performan improvement committee further evaluation or resolution. POC Date: 6	orwarded ce for	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		(X2) MULTIPLE A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/24/2011					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  316 WOODIES LANE BREMEN, IN46506					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	residents, they all hallways in the fi impeding their witimes.  On 5/18/11 at 6:4 near Room 122, observed: housel hall, 2 large barresoiled linen, one one of the wheel wheelchairs, 1 sy the medication caimpeding the transport of the medication was a.m., of a resider maneuvering his	made on 5/18/11 at 7:10						
F0253 SS=E	maintenance serving a sanitary, orderly Based on observing record review, the resident care equipment of the sanitary of the s	rovide housekeeping and ices necessary to maintain , and comfortable interior. ations, interviews, and e facility failed to ensure ipment and resident ere clean and in good he lounge and dining	F0253	F-253  It is the practice of this facilir ensure the highest quality or is afforded our residents.  Consistent with this practice	f care			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155474 05/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 316 WOODIES LANE BREMEN HEALTH CARE CENTER BREMEN, IN46506 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE areas for 2 of 2 lifts used for residents following has been done: The corrective action taken for the who need assistance with mechanical residents found to have been transfers, for 2 of 2 residents (#27, #28) affected by the deficient practice with padded siderails, and for 8 of 8 was: The side rails for residents residents with wheelchairs (Resident's: #27 and #28 where thoroughly cleaned. The wheelchairs for #54, 14, #55, #18, #12, #70, #9, and #15) residents #54, #14, #55, #18, for 1 of 19 residents in a sample of 19 and #12, #70, #9, #15 were 9 of 9 residents in a supplemental sample thoroughly cleaned. The of 30. mechanical lifts were cleaned. The carpet in the North Lounge has been extracted and free of Findings include: wet spots. The unresolved tile work in the dining room has been 1. During a tour of the facility on 5/20/11 completed. The cushion of resident #3's wheelchair was at 2:30 p.m., accompanied by cleaned during the course of the Maintenance Director #41 and the survey. The corrective action Housekeeping Director # 42, a standing taken for those residents having lift on the south unit was observed to be the potential to be affected by the same deficient practice is:No ladened with dirt debris and food other residents were found to substance. A Hoyer lift observed on the have been affected by the north unit was observed to be laden with deficient practice. The measures black dirt debris. put into place and a systemic change made to ensure the deficient practice does not recur During an interview at this time with the is: A cleaning schedule has been Housekeeping Director # 42 regarding the established for side rails, mechanical lift and the Hoyer lift, he wheelchairs, wheelchair cushions indicated they are used for transferring and mechanical lifts to ensure ongoing cleanliness. Carpeted some of the residents. areas are on a routine cleaning schedule and will be monitored 2. The north lounge carpet was observed on a daily basis by housekeeping supervisor or facility manager for to have a large wet area in front of the immediate resolution. All staff lounge door. The wet carpet was adjacent has been in-serviced on the to the shower room. The Maintenance importance of incontinence care, Director indicated the wetness probably elimination of odors, and clean leaked through from the shower room. wheel chairs and wheel chair

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPI 05/24/2	LETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  316 WOODIES LANE BREMEN, IN46506				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	Е	(X5) COMPLETION DATE
	indicated there we the shower room carpet became we are some we are the carpet became we are residents to observed to have from the floor. To grout in the space had plastic space walls near the king observed to be begue on the wall. During an interval Administrator or regarding the unit	ne north dining room eat their meals was ceramic tiles 4 foot up the tiles failed to have the es. Several of the tiles the grooves. The techen entrance was the with orange colored board.  The with the the failed to have the grooves. The techen entrance was the with orange colored the failed with the the failed have the with the failed have the fail			cushions. The facility implemented a wheelchair/cushion-cleaning schedule and a facility wall through to see if there were other issues causing odors ensure the deficient praction not recur, the monitoring sestablished is: A Performan Improvement indicator has established which evaluate compliance with eliminatio odors and maintaining cleatequipment. The Executive Director or designee will confide indicator weekly for the first month, monthly for the first quarter and quarterly there with results forwarded to the facility performance improved committee for further evaluation. POC Date: 6/	e any e any e does e does e been es n of en emplete t after e ement eation	
	of soiled wheel croom on 5/16/11 54's wheel chair substance on the 5. Resident #14's brake of his wheel dried food.	observations were made hairs in the main dining at 6:00 P.M.: Resident # had a dried white metal frame and leg rest.  front wheels, frame, and el chair were soiled with					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155474		LDING	NSTRUCTION  00	(X3) DATE COMPI 05/24/2	LETED	
	PROVIDER OR SUPPLIER		 316 WO	DDDRESS, CITY, STATE, ZIP CODE DODIES LANE EN, IN46506		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
		on dried substance on the ame, and front wheels.				
		s front right wheel of his soiled with a dried brown				
		s front wheels and frame ir were soiled with a tance.				
		s right large wheel of her soiled with a dried brown e.				
		s large wheel and spokes a large amount of a white				
	were covered wi crusty dried subs dried substance v framework. The	's foot pads and pedals th a dried white and beige stance. An orange/red was on the right side right and left brake had es and the seat of his dried spillage.				
	observed transfe bed via a mechan (5/16/11). Reside with urine but he dry upon investig	ad LPN #25 were rring Resident #3 to her nical lift at 4:20 P.M. ent #3's slacks were wet er incontinence brief was gation. Further the source of odor				

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	LDING	00	COMP	LETED		
		155474	B. WIN			05/24/2	2011		
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE				
NAME OF I	PROVIDER OR SUPPLIE	R		316 WOODIES LANE					
BREMEN	N HEALTH CARE C	ENTER		1	EN, IN46506				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	į	(X5)		
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	COMPLETION		
IAG		<u> </u>	+	IAG	DEFICIENCY)		DATE		
		e pool of urine underneath							
	1 ^	ucing cushion in her							
	wheel chair. The	e top and bottom of the							
	cushion were w	et with urine.							
	13. During an c	observation on 5/16/2011							
	1	sident #27's was noted to							
	l	ncil eraser sized white and							
	1	bstances on the padded							
	*	ostances on the padded							
	side rail.								
		observation on 5/16/2011							
	at 6:34 a.m., Re	sident #28's was noted to							
	have several per	ncil eraser sized white and							
	yellow, dried su	bstances on the padded							
	side rail.	•							
	An interview w	as conducted in the Nurses							
		11 at 11:02 a.m., with RN							
		ated that the white and							
	*	es on the padded side rails							
	has been there a	nd should probably be							
	cleaned off by o	ne of the CNAs.							
	3.1-19(f)								
	J.1-17(1)								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4EZC11

Facility ID: 000506

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLI	ETED
		155474	B. WING		<del></del>	05/24/20	011
			D. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				OODIES LANE		
BREMEN	I HEALTH CARE CE	ENTER			N, IN46506		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	1	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		-E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0272 SS=D	The facility must of periodically a comstandardized reproduced resident's further assessment of a react resident's further assessment of a react resident's further assessment of a react resident and continuous constitution. Constitution and behavior psychosocial well-physical functioning Continence; Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentian Documentation of regarding the additional performed through protocols; and Documentation of Based on observative record review, the perform an assess respiratory declination. This definition assess respiratory declination of 19 residents reside	onduct initially and prehensive, accurate, oducible assessment of national capacity.  Ase a comprehensive esident's needs, using the ne State. The assessment ast the following: demographic information; es; demographic information tional assessment in the resident assessment participation in assessment. Eation, interview, and the facility failed to: essment following a me and assess for pain efficient practice affected 2 deviewed for	F02	272	F-272  It is the practice of this facility ensure the highest quality of is afforded our residents.  Consistent with this practice, following has been done: The corrective action taken for the	care the	06/23/2011
of 19 residents reviewed for comprehensive assessments in a sample of 19. (Res# 27, 40)				_	e n tice		
					accessment was completed i	<u> </u>	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4EZC11

Facility ID:

000506

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155474 05/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 316 WOODIES LANE BREMEN HEALTH CARE CENTER BREMEN, IN46506 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Findings include: resident #27. Despite omission in the MAR, the nurse documented administration of resident #40's 1. Resident #27's record was reviewed on pain medication in the nurse's 5-16-2011 at 10:15 a.m. Resident #27's progress notes. The corrective diagnoses include, but were not limited to, action taken for those residents having the potential to be affected brain injury, quadriplegia, dysphagia, and by the same deficient practice is: vegetative state. A full facility audit was conducted and all pain assessments On 5/16/2011 at 6: a.m., Resident #27 updated. In addition, all residents were reviewed for additional was observed during tour with a needed respiratory assessment. tracheotomy and oxygen at 4 liters via a No other residents were found to tracheotomy mask. be in need of additional respiratory assessment. The measures put into place and a On 5/16/2011 at 6:11 p.m., RN # 6, RN systemic change made to ensure #7, RN #8 and the ADON (Assistant the deficient practice does not Director of Nursing) were observed recur is: Licensed nursing staff providing care to Resident # 27. Once has been in-serviced related to respiratory and pain assessment. care was completed, all the staff except In addition licensed nurses have the ADON left the room. completed return demonstration At 6:30 p.m., when surveyors were and competency testing related to exiting the room a large amount of mucus suctioning and tracheostomy was noted inside of the outer cannula of care. To ensure the deficient practice does not recur, the the tracheotomy. The ADON was asked monitoring system established to lift the sheet to allow observation of the is:A Performance Improvement nail beds. Resident #27's nail beds were indicator has been established which evaluates compliance with blue/gray in color and the fingers were respiratory and pain assessment. mostly blue in color. Resident #27 was The Director of Nursing or also noted to be experiencing a violent designee will complete indicator cough. The inner lumen of the oxygen weekly for the first month, monthly for the first quarter and tubing was noted to be completely quarterly thereafter with results obstructed with mucus. forwarded to the facility At 6:42 p.m., RN #8 was requested to performance improvement return to the room with a biox (to test committee for further evaluation or resolution. POC Date: 6/23/11 blood oxygen levels), Resident # 27's biox

Facility ID:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155474		(X2) M A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE S COMPL <b>05/24/2</b> (	ETED	
NAME OF	PROVIDER OR SUPPLIEI	<b>"</b> }	•		ADDRESS, CITY, STATE, ZIP CODE		
BREMEN	N HEALTH CARE C	ENTER		1	OODIES LANE N, IN46506		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
TAG	was 84%.	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
		N #8 brought suction					
		om. Resident #27					
	observed coughi						
	At 6:54 p.m., Re	esident #27's biox is 87%,					
	oral mucus secre	etions visualized, Resident					
	#27 was observe	0 00 0					
	_	e biox was 86%, mucus					
	1	rgling from resident's					
	mouth.	aidant #27la raam and					
	_	sident #27's room and olently, gagging, and					
	1	in bed. Biox was 89%.					
		lifferent biox was brought					
	1 .	ident #27's biox was then					
	93%.						
	1	p.m., RN #8 verified that					
	1	perienced a decline in					
	1 ^ -	tion on 5/16/11 from 6:11					
	1 -	.m. RN #8 indicated a					
	1 1	sment was not completed ng or immediately after					
	1 ^	staff to determine lung					
	function/sounds.						
	Tanonon Sounds.						
	The policy titled	, "Comprehensive					
	Assessment" dat	ed 3/05/08 was reviewed					
	on 5/24/11 at 2:3	-					
		ssessment Data- Resident					
	data collected so						
	1	on of the resident's					
	1	ntal condition or abilities					
	may be determine	ned by the appropriate					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4EZC11 Facility ID:

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		A. BUI	LDING	NSTRUCTION  00	(X3) DATE ( COMPL <b>05/24/2</b>	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER	2		1	OODIES LANE		
	N HEALTH CARE C			1	N, IN46506		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG	+	,		TAG	DLI ICILICI I		DATE
	1 *	is documented on					
	1	s. Data may include, but					
	changesObserv	Vital signsResident					
	1 -	e oximetryResponse to					
	1	etiveness of treatment					
	Oral status"	tiveness of treatment					
	Orar status						
	The policy titled	, "Endotracheal Care &					
	1 ^ *	ed 10/31/07, was					
		4/11 at 2:45 p.m., stated,					
	1	ioning of the resident's					
	1	increased secretions and					
	prevents airway						
		cations for Suctioning-					
	1 ^	r congested-sounding					
	1 ^	ecretionsDecreased					
	~	d/or oxygen saturation (as					
	indicated by puls	se oximetry), thought to					
	be related to mu	cus pluggingHazards					
	and Complicatio	ns- Trauma to the oral,					
	tracheal, or bron	chial mucosa; Cardiac					
	arrest; Respirato	ry arrestbronchospasm					
	or bronchoconst	riction; Airway					
		dureAssessment of					
	outcomeDocui						
	Guidelines2						
		te and time of physician					
		Notification of family					
	member/respons	2 2					
		's clinical record was					
		6/11 at 2:35 P.M. and					
	1	ses of, but not limited to:					
	history of sacral	pelvic fracture,					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE COMPL	ETED
	PROVIDER OR SUPPLIER		•	316 WC	DODIES LANE N, IN46506		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE
mo	osteoporosis, ma	cular degeneration, senile steoarthritis of the hips.		mo			DILL
	unit on 5/16/11 a accompanied by Resident #40 had fractured right his the unit. Resident grimacing and in pain at the time.  Resident #40 was 12:25 P.M., screshe was pulled us and CNA #5. Resident Medication Adm (MAR) on 5/16/indicated she had Norco (narcotic (milligram) at 6:650 mg. of aceta (over-the-counter of Tramadol (normedication) at 8:00 During interview of the above obsineed to get some her." Further revindicated LPN #5	s observed on 5/16/11 at aming out in pain when p in her bed by LPN #2 eview of Resident #40's inistration Record 11 at 12:30 P.M., d been medicated with pain medication) 5 mg. 00 A.M. She received minophen r analgesic) and 100 mg. n-narcotic pain 100 A.M.  with LPN #2, at the time ervation, she stated, "We ever of the PRN (Norco) in view of the MAR 2 medicated Resident #40					
	,	s needed) Norco 5 mg. at ner breakthrough pain.					

'			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155474	B. WIN			05/24/2	011
			_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	ę.		316 WC	OODIES LANE		
	N HEALTH CARE C				EN, IN46506		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	1 -	der, dated 5/4/11 at 1:20					
	P.M., indicated,						
	1 ` *	mg [milligram]-325 mg					
	1 -	ophen]) tablets. Give i					
	(one) PO (by mo	,					
	times/day) 6 A.N	M., 2 P.M., 10 P.M.					
	Keep PRN (as n	eeded) Norco order for					
	breakthrough pa	in"					
	Resident #40's N	MAR indicated she					
	received the PRI	N (as needed) Norco for					
	breakthrough pa	in on the following dates					
	1 - ^	nes (x's) on 5/04/11: 12:30					
		no routine Norco given on					
	` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` `	5/05/11: 6:00 P.M.; 3 x's					
	1	A.M., 10:00 A.M., and					
	1	n 5/07/11: 10:15 A.M.; 3					
	1						
		:00 A.M., 10:00 A.M.,					
	1	x on 5/09/11: 2:00 A.M.;					
		5:00 P.M.; 1 x on 5/13/11:					
	1	n 5/14/11: 6:00 P.M.; 2					
		2:30 P.M. and 4:00 P.M.;					
		t 2:00 A.M. Resident #40					
		of 17 doses of the PRN					
	`	through pain) over the 15					
	day period of 5/0	04/11 through 5/18/11.					
	On 5/16/11 at 4:	50 P.M., Resident #40					
	indicated in an in	nterview she was having					
	"bad" pain in he	r right hip and was fearful					
	of being moved	in bed. Review of her					
	MAR, at the tim	e, indicated she had not					
		:00 P.M. scheduled dose					
		d received another dose					

l	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	TE SURVEY  IPLETED  1/2011
	PROVIDER OR SUPPLIER		316 WC	ADDRESS, CITY, STATE, ZIP CO DODIES LANE EN, IN46506	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	mg. of the Trama	cetaminophen and 100 adol at 2:00 P.M. She dose of Norco at 4:00				
	5/17/11 at 9:10 A was having pain unable to rate he scale. The MAR	with Resident #40 on A.M., she indicated she in her right hip, but was r pain on the 0-10 pain indicated a Norco 5 mg. en to Resident #40 at				
	P.MYells out 9:45 P.MReside any movement	dicated, "5/17/11 at 3:45 when moved5/17/11 at ent has lots of pain with 5/18/11 at 10:00 A.M. R hip. Pain when pulled assist"				
	indicated in an ir 11:15 A.M., a Ph obtained for Mor fast-acting pain r administered eve breakthrough pai wasn't controlling	Nursing (D.O.N.) Interview on 5/18/11 at a sysician's Order had been rephine Sulfate (a strong, narcotic) 5 mg. to be arry two hours for n. "The Vicodin (Norco) g her pain. We were icodin, but it wasn't				
	indicated, "Morp	er, dated 5/18/11, hine Sulfate Suspension ter) give 5 mg. PO or				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		A. BUII	LDING	NSTRUCTION 00	l ′	E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ODIES LANE N, IN46506		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	(X5) COMPLETION
TAG	sublingual Q 2 h breakthrough pai	` '		TAG	DEFICIENCY)		DATE
	CNA #12 and CN providing incont #40 on 5/19/11 a moaned when the lowered to a flat out in pain when Resident #40 wa so she could be win pain as she wareached across the Resident #40's ripushed on her rigonto the left hipout in pain and y No. No."  Review of the M #40 had not rece Sulfate since 4:0  Resident #40's C indicated, "Problem Resident Fall. Go complications and fracture. Approach	NA #14 were observed inence care to Resident t 1:10 P.M. Resident #40 e head of her bed was position and screamed her legs were touched. It is rolled onto her right hip washed. She screamed out its rolled. CNA #14 then he bed and pulled on ght thigh while CNA #12 ght hip to turn her over Resident #40 screamed elled "My leg. My leg.  AR indicated Resident itved her Morphine O A.M. on 5/19/11.  are Plan, dated 5/10/11, em: Fracture: Right Hip oal: Resident will have no ad minimal pain from hip eh:Administer pain dered and check for					
	1 '	titled "Pain evised 4/28/09, indicated, ter's practice is to assist					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION 00	(X3) DATE COMP 05/24/2	LETED
	PROVIDER OR SUPPLIER		316 WC	ADDRESS, CITY, STATE, ZIP CO DODIES LANE EN, IN46506	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	potential for pair the highest pract and functioning management6. orientation and o correct misconce about pain. Train	The center provides ingoing staff education to eptions, myths, and biases ing my (sic) include, butb. recognizing and				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	DING	00	COMPL	ETED
		155474	A. BUII B. WIN			05/24/2	011
			b. WIN		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER				OODIES LANE		
DDEMEN	I HEALTH CARE CE	ENTED		1	N, IN46506		
DICEIVILIN	THEALTH CARE CI	ENTER		BREIVIE	11, 11140300		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0278		nust accurately reflect the					
SS=A	resident's status.						
	A registered nurse must conduct or coordinate						
		with the appropriate					
	participation of he						
	, ,	•					
	A registered nurse	must sign and certify that					
	the assessment is	completed.					
		no completes a portion of oust sign and certify the					
		ortion of the assessment.					
	accuracy of that p	ortion of the assessment.					
	Under Medicare a	nd Medicaid, an individual					
	who willfully and k	nowingly certifies a material					
		nt in a resident assessment					
		money penalty of not more					
		ich assessment; or an					
		fully and knowingly causes to certify a material and					
		a resident assessment is					
		noney penalty of not more					
	than \$5,000 for ea						
		nent does not constitute a					
	material and false						
		review and interview,	F0	278	F-278		06/23/2011
	the facility failed	to ensure the MDS			_	ı, to	
	(Minimum Data	Set) was accurate for 1 of			It is the practice of this facility ensure the highest quality of		
	19 residents revi	ewed for MDS's in a			is afforded our residents.	54.5	
	sample of 19.				Consistent with this practice,	the	
	1				following has been done: The	e	
	Resident # 87				corrective action taken for the		
	$\pi$ $\sigma$				residents found to have beer		
	Piudius 1 1 1				affected by the deficient prac		
	Findings include	:			was:The diagnosis of Hepatit	iis C	
					was added to the MDS for resident number #87 on 5/23	1/11	
		ecord for Resident # 87			and transmitted. The correcti		
	reviewed on 5/19	9/11 at 1:45 P.M.,			action taken for those reside		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	00	COMPL	ETED
		155474	A. BUII		-	05/24/2	011
			B. WIN				
NAME OF I	PROVIDER OR SUPPLIEF	<b>t</b>			ADDRESS, CITY, STATE, ZIP CODE		
					OODIES LANE		
BREMEN	I HEALTH CARE C	ENIER		BKEWE	EN, IN46506		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	_	ses of, but not limited to,			having the potential to be aff		
	hepatitis C, spina	al cord disease,			by the same deficient practic		
	paraplegia, and o	chronic pain.			The medical records for all o		
		1			residents were audited to en- active diagnoses are indicate		
	Review of the "F	Resident Care System,			appropriately on the MDS for		
		- · · · · · · · · · · · · · · · · · · ·			last two physician visits. Any		
	_	Order", printed 3/30/11,			other MDS's required to be		
		T (hepatitis) Ceffective			submitted to the state will be		
	date2/24/11a	dmit date 2/24/11			submitted as needed. <i>The</i>		
					measures put into place and		
	The MDS (Mini	mum Data Set), dated			systemic change made to en		
	4/20/11, Section	I - Active Diagnoses			the deficient practice does no		
		tation of Hepatitis C.			recur is: The MDS coordinate will ensure active diagnoses		
					reflected on current physicial		
	During daily oor	aference on 5/23/11 at			orders as evidenced by resid		
					history and physical and dict		
	· ·	ON (Director of Nursing)			progress notes. The MDS st		
		the lack of Resident #			has been in-serviced related	to	
	87's diagnosis of	Hepatitis C being			ensuring all active diagnoses		
	documented on t	the MDS. She further			indicated on the MDS. To e		
	indicated she wo	ould talk with the MDS			the deficient practice does no		
	coordinator.				recur, the monitoring system		
	• • • • • • • • • • • • • • • • • • • •				established is:A performance improvement indicator has be		
	2 1 21(4)				established that evaluates th		
	3.1-31(d)				compliance of active diagnos		
	3.1-31(i)				appropriately reflected on the		
					MDS. The Director of Nursir		
					designee will complete indica	ator	
					weekly for the first month,		
					monthly for the first quarter a		
					quarterly thereafter with resu	Its	
					forwarded to the facility		
					performance improvement committee for further evaluat	ion	
					or resolution. POC Date: 6/2		
					- 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		A. BUILDI		STRUCTION  00	(X3) DATE S COMPL <b>05/24/2</b>	ETED	
	PROVIDER OR SUPPLIER		3	316 WO	DDRESS, CITY, STATE, ZIP CODE ODIES LANE N, IN46506		
(X4) ID PREFIX TAG F0279	(EACH DEFICIEN) REGULATORY OR A facility must use		PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
SS=E	assessment to deveresident's compreled. The facility must do care plan for each measurable object a resident's medic psychosocial needs comprehensive as.  The care plan must are to be furnished resident's highest mental, and psych required under §44 would otherwise be but are not provide exercise of rights or right to refuse treat Based on observating to resident's highest mental, and side rail resident's highest mental, and psychological and psychological resident's highest mental, and psychological and psychological resident's reviewed care plans in a sail of 11)  Findings include  1. Resident #92	evelop, review and revise the nensive plan of care.  evelop a comprehensive resident that includes tives and timetables to meet al, nursing, and mental and les that are identified in the sessment.  It describe the services that do attain or maintain the practicable physical, osocial well-being as 33.25; and any services that the required under §483.25 and due to the resident's under §483.10, including the timent under §483.10(b)(4).  Interview, and the facility failed to create care plan to address all the patitis C, mechanical the pads to ensure the service of physical, thosocial well being is saiding in this facility. The pads for comprehensive the property of the pads of the pad	F027	79	F-279  It is the practice of this facility ensure the highest quality of is afforded our residents.  Consistent with this practice, following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was:The care plans for reside #92, #87, #10 and #11 have reviewed and amended to income the following: #92 – a preventative care plan for pressure ulcers#87 – a care related to the diagnosis of Hepatitis C#10 – use of padd rails#11 – appropriate equipm for transfers The corrective at taken for those residents have the potential to be affected by	the et tice ents been clude plan led nent ction ring	06/23/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4EZC11 Facility ID:

000506

If continuation sheet

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li '		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155474	B. WIN	G		05/24/2011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	ROVIDER OR SULLER			316 WC	OODIES LANE	
BREMEN	N HEALTH CARE C	ENTER		BREME	EN, IN46506	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	diagnoses includ	e, but were not limited to,			same deficient practice is: T	I
	dementia, periph	eral neuropathy, edema,			care plans for all residents w reviewed to ensure they	ere
	and hemiplegia.				accurately reflect the resider	ıt's
					current status. The measur	I
	The "Resident Pr	ogress Notes," dated			put into place and a systemic	;
	1/4/11 at 8:20 a.r	n., stated, "Res (resident)			change made to ensure the	
		h) 2 new bruises this am			deficient practice does not re	ecur
	,	ck of heels bilaterally. R			is: The care plans of each resident will be updated durit	na
		asures 1.2 c.m. x 0.5			the Monday through Friday	' <sup>9</sup>
	1 ` • ′	ise measures 1 c.m. x 0.4			clinical meeting with receipt of	of
	c.m. MD notifie				any new orders, diagnosis o	
	C.III. IVID HOUSE	u.			assistive care device. To er	• • • • • • • • • • • • • • • • • • •
	The Dhysician O	rders, dated 1/5/11 at			the deficient practice does no	I
	1 -				recur, the monitoring system established is:A performance	• • • • • • • • • • • • • • • • • • •
		d, "Proderm to bilateral			improvement indicator has b	• • • • • • • • • • • • • • • • • • •
		times daily) until			established that evaluates th	I
	healed"				compliance with the presenc	• • • • • • • • • • • • • • • • • • •
					care plans accurately reflect	
		of the "Weekly Pressure			care needs of the residents.	
	Ulcer Condition	Report," indicated that			Director of Nursing or design will complete indicator weekl	
	the bilateral heel	wounds were healed on			the first month, monthly for the	
	5/18/11. This rep	port also stated, "Date			first quarter and quarterly	
	of first observation	on: 1/4/11" for bilateral			thereafter with results forwar	ded
	heel wounds.				to the facility performance	
					improvement committee for further evaluation or	
	An interview was	s conducted on 5/19/11 at			resolution. POC Date: 6/23/1	1
		LPN #3. LPN #3 was			1.200.0.0	
		care plan addressing				
		re of heel pressure ulcers.				
	1 ^	d that the documentation				
	should be on the					
	should be on the	Chart.				
	The policy titled.	"Pressure Ulcer				
		ed 4/28/09, was reviewed				
		0 p.m., and stated,				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155474			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S	ETED	
		155474	B. WIN			05/24/2	011
NAME OF I	PROVIDER OR SUPPLIEI	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
RDEMEN	N HEALTH CARE C	ENTED		1	OODIES LANE EN, IN46506		
							77.0
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES  NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	"Policy- A reside	ent who enters the center					
	1 -	ulcers and/or other					
	1 *	ers does not develop					
	1 1	and/or other non-pressure					
	_	e individual's clinical					
	condition demor	nstrates that they were					
		ne center provides care					
	and services to:	a. Promote the prevention					
		development b. Promote					
	the healing of pr	essure ulcers that are					
	present (includir	ng prevention of infection					
	to the extent pos	sible); and c. Prevent					
	development of	additional pressure					
	ulcers15. Deve	elop care plan on the					
	degree and areas	of risk and update as					
	necessary"						
	2. The clinical r	record for Resident # 87					
	reviewed on 5/1	9/11 at 1:45 P.M.,					
	1	ses of, but not limited to,					
	hepatitis C, spin						
	paraplegia, and	chronic pain.					
	1	Physical," dated 2/26/11,					
	1 * '	Jame) M.D., indicated,					
	1 -	ght now he will be on					
	universal precau	tions"					
	Trl1: 1						
		ord lacked documentation					
	1	are plan regarding the					
	diagnosis of Hep	Datius C.					
	CNA # 22 on 5/	19/11 at 3:55 P.M.,					
		is unaware of the					
		osis of Hepatitis C.					
	I resident s diagn	osis of frepantis C.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		NSTRUCTION 00	(X3) DATE S	ETED	
		155474	B. WIN			05/24/2	U11
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BREMEN	I HEALTH CARE CE	ENTER			EN, IN46506		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
	6:30 P.M., the Dowas informed of related to Resider Hepatitis C. No presented to the sexit on 5/24/11.  A facility policy revised 10/31/06 Precautions, Standard 10/31/06 Precautions, Standard 10/31/16/11 at 10:00 record indicated limited to; stroke diabetes, aphasia disorder and hypothesis and the properties of the p	s record was reviewed on a.m. The Resident's diagnoses of, but not e, gastric feeding tube, dysphasia, seizure ertension.  the facility on 5/16/11 at the ervation was made of ide rails padded with are plan, updated on d, "Problem: Seizure rails up X (times) 2 as nsApproach: 1/2 side ) 2 as seizure					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		(X2) MUI A. BUILI B. WING	DING	NSTRUCTION  00	(X3) DATE COMPI 05/24/2	LETED	
	PROVIDER OR SUPPLIER		p. wind	STREET A	DDRESS, CITY, STATE, ZIP CODE ODIES LANE N, IN46506		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3	(X5) COMPLETION DATE
	During an interviols 16/16/11 at 7:10 a knowledge, the spadded. She indishould have been the padded rails.	iew with LPN # 9, on .m., she indicated to her ide rails are always kept cated the care plan ideveloped to always use					
	5/17/11 at 3:20 p indicated diagnos	.m. The Resident's record ses of, but not limited to; ower limbs, pressure					
	During an interview with alert and oriented Resident # 11 on 5/18/11 at 2:10 p.m., he indicated he gets up occasionally and the staff use a Hoyer lift to transfer him. He further indicated he is not able to be up long due to his pressure ulcers.						
	1 ^ *	ler, dated 4/12/11, (mechanical) lift for all					
	5/17/11 at 3:40 p to indicate how t transferred. The indicate a Hoyer	lan of care reviewed on .m., dated 4/19/11 failed he resident was plan of care did not lift was used or how d be used to transfer the					
	l	ated 5/6/11 at 9:30 a.m., ed and rep (repositioned)					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155474	A. BUILDING	00	COMPLETED 05/24/2011
		155474	B. WING	A DDDDGG GITTY GTATE ZID GODE	03/24/2011
NAME OF F	PROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE  DODIES LANE	
BREMEN	I HEALTH CARE CE		l l	EN, IN46506	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
1710		(mechanical) lift and 2	ind	·	DATE
	assist for all trans	` '			
	assist for all trails	51015			
	3.1-35(a)				
F0280 SS=D	incompetent or oth incapacitated under	he right, unless adjudged nerwise found to be er the laws of the State, to ning care and treatment or nd treatment.			
	of the comprehens by an interdisciplin attending physicial responsibility for the appropriate staff in by the resident's number of the resident's family representative; and revised by a team each assessment. Based on observative record review, the a care plan had be resident reviewed weight loss in a second staff of the resident for the resident for the resident reviewed weight loss in a second staff of the resident for the res	days after the completion sive assessment; prepared hary team, that includes the n, a registered nurse with the resident, and other n disciplines as determined the eds, and, to the extent articipation of the resident, ly or the resident's legal diperiodically reviewed and of qualified persons after ation, interview and the facility failed to ensure the een updated for 1 of 1 did with a significant sample of 19. (Resident #	F0280	F-280 It is the practice of this facilit ensure the highest quality of is afforded our residents. Consistent with this practice, following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: The care plan for reside #54 has been reviewed and amended related to significal weight loss. The corrective at taken for those residents have the potential to be affected by	tare  the the the the the the the the the t

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155474 05/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 316 WOODIES LANE BREMEN HEALTH CARE CENTER BREMEN, IN46506 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE residents will be reviewed to osteoporosis and cardiomegally. identify any other significant weight loss. Appropriate care On 5/17/11 at 1:00 p.m., Resident # 54 plans and interventions will be was observed in the dining room. The initiated as necessary. The measures put into place and a resident was observed refusing to eat her systemic change made to ensure lunch. Staff attempted to assist the the deficient practice does not resident with her meal, she refused to eat. recur is: The Registered dietician has been in-serviced on timely The Resident's weights for the month of updating of care plans and associated interventions. To January 9th, 2011 was 141 pounds. ensure the deficient practice does February 9th, 2011's weight was 155.2. not recur, the monitoring system March 6th, 2011 weight was 156.7 established is: A performance pounds. April 2011 weight was 155.5, improvement tool has been developed which evaluates the and May 2011 weight was 128.5. The presence, timeliness and resident's reweight for May was recorded appropriateness of care plans for at 126.9 pounds. The weight loss those residents who have calculated at 28.6 pounds lost from April experienced a significant weight loss. The Director of Nursing or to May, 2011. designee will complete indicator weekly for the first month, The resident's plan of care, dated 3/15/10, monthly for the first quarter and indicated "Problem: Significant weight quarterly thereafter with results loss (March 2010) Leaves 25% or more forwarded to the facility performance improvement uneaten most meals, at risk for choking committee for further evaluation Dx (diagnosis) Hiatal Hernia, Dx: or resolution. POC Date: 6/23/11 Dysphagia...Approach:...Notify RD and MD of significant weight changes...." The resident's plan of care was last updated on 4/5/11. No further documentation was observed on the plan of care to address the 28.6 pound weight loss the resident experienced. The plan of care failed to indicate the resident refuses to eat her meals at times.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4EZC11

Facility ID:

000506

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3			(X3) DATE S	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155474	B. WING		<del></del>	05/24/2	011
			D. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	-			ODIES LANE		
BREMEN	I HEALTH CARE CI	ENTER			N, IN46506		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Nursing regarding 5/20/11 at 5:10 pcare plan should the weight loss where the weight loss where the facility's policy in facility's policy in facility in the facility's policy in facility in facility in the fa	roblem and/or ge," dated 10/31/10, afficant Change, a decline in a patient's status that: ally resolve itself without taff or by implementing d-related clinical not "self-limiting", b. an one area of the tatus; and c. Requires review of the care plan to include the					
	3.1-35(a)						
F0281 SS=D	facility must meet quality. Based on observe record reviews, t ensure a resident tube and receiving pump was cared	ided or arranged by the professional standards of ation, interviews and he facility failed to with a gastric feeding ag nutrition through a for by a licensed staff residents reviewed with	F0:	281	F-281  It is the practice of this facility ensure the highest quality of is afforded our residents.  Consistent with this practice, following has been done: The corrective action taken for the	care the	06/23/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		, DDIG	00	COMPL	LETED
		155474		LDING		05/24/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R		1			
DDEME	NULEALTU CARE C	SENTED		1	OODIES LANE		
BKEMEI	N HEALTH CARE C	ENTER		BREME	EN, IN46506		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	gastric feedings	in a sample of 19			residents found to have bee	n	
	(Resident # 10),	and also failed to have			affected by the deficient pra		
	nursing staff with sufficient knowledge of tracheotomy suctioning for 1 of 1				was:CNA #24 was educated		
					related to scope of practice		
	-	_			include not hooking or unhoon the g-tube feeding for any	oking	
		tracheotomy needing to			resident. Licensed nurse ve	arifiad	
	1	a sample of 19 (Resident #			placement and checked resi		
	27).				of resident #10's g-tube follo		
					the incident. RN #8 was	Ū	
	Findings include	<del>2</del> :			immediately re-educated on		
					sterile technique and comple		
	1 Resident # 10	's record was reviewed on			tracheostomy suctioning per		
	1	a.m. The Resident's			facility policy. The physiciar		
					resident #27 has completed assessment and completed		
		diagnoses of, but not			updated physician progress		
	•	e, gastric tube, diabetes,			relative to the resident's	note	
	dysphagia and a	phasia.			condition. The corrective a	ction	
					taken for those residents ha		
	The Resident's r	ecord indicated she			the potential to be affected b	-	
	receives gastric	feedings by way of a			same deficient practice is:N	0	
	1	cubic centimeter) and hour			other residents have been		
	continuously.				observed to be affected by t		
	Continuously.				practices. The measures p		
	<b>.</b>	24 1 4			place and a systemic chang		
	1 -	the resident's room on			made to ensure the deficien practice does not recur is:	ı	
		p.m., an observation was			Certified nursing assistants	nave	
	made of CNA#	24 transferring Resident #			been in-serviced related to s		
	10 into her recli	ner via a Hoyer lift. The			of practice to include G-Tub		
	resident was obs	served to be unhooked			care. All licensed nursing st		
	from her feeding	g pump during the			has been in-serviced and		
	I -	he resident was placed in			completed competency testi	•	
		# 24 was observed to hook			and return demonstration re	ated	
	1				to tracheostomy care and		
	1	ding to Resident # 10's			suctioning. The Staff Development Coordinator ha	96	
	gastric tube and	turn the pump on to 45			and will continue to observe		
	cc/hour.				staff suctioning during trach		
					To ensure the deficient prac		
	During an interv	view with LPN # 25 on			does not recur, the monitorii		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING 00		COMPI	COMPLETED	
	155474		A. BUI B. WIN	A. BUILDING			2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1	OODIES LANE		
DDEMEN	N HEALTH CARE C	ENTED		1			
DKEWE	N HEALTH CARE C	ENIER		DKEIVIE	N, IN46506		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	<b>+</b>	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	5/16/11 at 3:40 p	o.m., regarding a CNA			system established is:A		
	hooking up the	resident's tube feeding and			Performance Improvement		
	turning on the p	ump, LPN # 25 stated			indicator has been establish which evaluates compliance		
	1 .	not supposed to unhook			observing certified nursing	WILII	
		tube (gastric tube.) LPN #			assistants in provision of car	re to	
	1	d a nurse would need to			ensure no violation of scope		
		nent and the residual prior			practice and direct care		
	1	•			observations of licensed sta		
	to starting a feed	ling.			across all three shifts on the	!	
					proper technique related to	_	
		ppincott's Manual of			suctioning and tracheostomy care. The Director of Nursir		
	Nursing Practice	e 4th Edition regarding			designee will complete indic		
	gastric feeding t	ubes "Continuous Nursing			weekly for the first month,	atoi	
	Assessment, 1, I	Recognize that even			monthly for the first quarter	and	
		tritional deficits are			quarterly thereafter with resu	ults	
	1	problems may arise, such			forwarded to the facility		
	· ·	•			performance improvement		
		esophageal reflux3.			committee for further evalua		
		ing prior to feeding to			or resolution. POC Date: 6/2	23/11	
	1	be is in place. 4. Avoid					
	air bubbles in th	e system which could					
	cause distention	"					
	2 Resident #27'	s record was reviewed on					
		:15 a.m. Resident #27's					
	diagnoses include, but were not limited to,						
		driplegia, dysphagia, and					
	vegetative state.						
	On 5/16/11 at 6:52 p.m., RN #8 was observed completing tracheotomy						
	_	esident #27. RN #8 broke					
	1	while putting sterile					
	1						
	-	by touching the sterile					
	i area with his bai	re hands. RN #8 also	- 1				1

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A PUBLICATION (X3) DATE SURVEY  COMPLETED					
			LDING		05/24/2011		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					OODIES LANE		
BREMEN	N HEALTH CARE CE	ENTER		1	EN, IN46506		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		suction catheter into					
		ore use to check for					
		pment and lubricate the					
		before beginning the					
	1 ^	then suctioned while					
	inserting the cath						
	1	ctioning was longer than					
		not intermittent. RN #8					
		hirty seconds between					
		des. There was no					
		sment completed during					
	or immediately a	fter this incident.					
	According to Lip	pincott's Manual of					
	Nursing Practice	4th edition for					
	suctioning a resid	dent with a tracheostomy,					
	"The patient with	an ineffective cough					
	cannot clear his s	secretions and requires					
	mechanical aspir	ation (suctioning). It is a					
	sterile procedure	. Secretion collection in					
	_	ay or tracheobronchial					
		n narrowing of the airway,					
	· ·	ficiency, increased work					
	of breathing and	stasis of secretions.					
	The policy titled.	, "Endotracheal Care &					
	Suctioning," date						
	1	1/11 at 4:15 p.m. stated,					
		ctioning of the resident's					
		increased secretions and					
	prevents airway						
		edure4. wash hands. 5.					
	_	heter package. 6. Put on					
	_	le gloves and remove					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474				NSTRUCTION 00	(X3) DATE S COMPL			
			A. BUII B. WIN			05/24/2011		
			B. WIN		DDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER		316 WOODIES LANE					
BREMEN HEALTH CARE CENTER				BREME	N, IN46506			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION	
IAG		7. With the un-sterile		IAG	BEITEENCTY		DATE	
		the resident from the						
	<i>'</i>	n. 8. Gently pass the						
		down the endotracheal						
		nce is met then withdraw						
		itly. 9. Apply suction						
	while removing t							
	_	e resident11. Repeat						
		all secretions have been						
	-	the resident's tolerance						
	of the procedure.							
	•	Determine if suctioning						
	has been success	ful by one or more of the						
	following: a. Rer	noval of secretions; b.						
	Improvement of	breath soundse.						
	clearing of cough	n13. When completed,						
	place resident ba	ck on the aerosol or						
	oxygenDocume	entation of						
	Guidelines2	a. Respiratory						
	status3a. Date	e and time of physician						
	notification4. N	Notification of family						
	member/responsi	ible party"						
	3.1-35(g)(1)							
F0282	The services provi	ided or arranged by the						
SS=E	facility must be pro	ovided by qualified persons						
		n each resident's written						
	plan of care.	ews, observations and	EU	282	<b>-</b>		06/23/2011	
		he facility failed to	10	202	F-282		00/23/2011	
		inc racinity raniculto	<u>L</u> _		It is the practice of this facility	y to		

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED		
		155474	B. WIN			05/24/2	011	
<u>u</u>				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIEF	ę.		316 WC	OODIES LANE			
BREME	N HEALTH CARE C	ENTER			N, IN46506			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	ensure residents	receiving gastric feedings			ensure the highest quality of	care		
	by way of a pum	p was properly positioned			is afforded our residents.	tho		
	in bed for 2 of 2	resident reviewed with			Consistent with this practice, following has been done: The			
	gastric feedings	(Residents: #10 and #27)			corrective action taken for th			
	1 -	ent needing his heels			residents found to have been			
		ned (Resident # 80) and			affected by the deficient practice			
	1	· · ·			was: Residents #10 and #27			
		ture 1 resident with			immediately repositioned as	per		
	thickened liquids	* *			facility policy for residents			
	-	uid at her bedside for 1 of			receiving gastric feedings. T			
	1 resident review	ved with thickened fluids			water pitcher was removed f the bedside table of resident			
	(Resident # 54) a	and for failing to ensure 3			during the course of the surv			
	residents receive	ed the correct dose of			The heels of resident #80 we			
	insulin for 3 of 5	residents reviewed with			repositioned to ensure flotati			
	insulin orders in				heels. The physician for			
	(Residents: # 11.	-			residents #3, #11 and #80 w	ere		
	(Residents. # 11,	, # 3 and # 80)			notified of the errors related			
	F: 1: : 1 1				sliding scale dosage or miss			
	Findings include	<b>:</b> :		doses of insulin. Resident #3				
					does not have physician order for glucometer testing at 12p			
	1. Resident # 10'	's record was reviewed on			and 6pm. This resident does			
	5/16/11 at 10:00	a.m. The Resident's			receive sliding scale insulin			
	record indicated	diagnoses of, but not			coverage for glucometer test	ting		
	limited to; stroke	e, gastric tube, diabetes,			at 6am and 4pm. Per review			
	dysphasia and ap	<del>-</del>			resident #3's MAR, the corre	ect		
		,			amount on insulin was			
	The regident's re	cord indicated she			administered for glucometer			
					results on 3/21/11, 3/24/11, a 3/25/11. In addition, the phy			
	1	feedings by way of a			for resident #3 was notified of			
	1 `	cubic centimeter) and hour			medication error related to			
	1	ne resident's record			Diltiazem and 02 sats with n	o new		
	indicated "Aspir	ation alert" on the			orders received. The correct			
	physicians order	sheet.			action taken for those reside			
					having the potential to be aff			
	During a tour of	the facility on 5/16/11 at			by the same deficient practic	e		
	1	ent # 10 was observed in			is:A facility wide audit was			
	1				conducted to identify those requiring elevated head of be	ed he		
	I nei bed with her	body flat. The resident's			requiring elevated flead of be	ou,		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155474		A. BUI	(X2) MULTIPLE CONSTRUCTION (X3) DATE  A. BUILDING  B. WING 00					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  316 WOODIES LANE BREMEN, IN46506					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES			ID PREFIX	ATE	(X5) COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	DATE	
	bed was raised, b	out the resident had slid			thickened liquids, sliding sc			
	down in the bed	placing her body in a flat			insulin and pressure relievir devices to ensure all neces	-		
	position. The res	ident's feeding pump was			interventions are in place	sai y		
	observed hooked	l up to the resident with			according to the resident's	olan of		
	the pump observ	ed running at 45 cc's			care. A facility wide medica	tion		
	(cubic centimete	rs) an hour.			administration record and			
		,			treatment administration rec			
	   During an interv	iew with the ADON at			audit for the month of June been conducted to review	nas		
	1	dicated the resident			compliance with all medicat	ions		
	<b>1</b>	n placed higher in the			requiring specialized param			
		i piaced inglier in the			Any variances to prescribed			
	bed.				treatment regime will be rep			
					to the physician for further r	eview		
		der, dated 6/10/05 to			and recommendation. The measures put into place and	-l -		
	current, indicated	d "HOB (head of bed) up						
	30 degrees at all	times."		systemic change made to ensure the deficient practice does not				
					recur is: Nursing staff has b			
	2. During a tour	of the facility on 5/16/11			in-serviced related to appro			
	at 7:00 a.m., an o	observation was made of			positioning to include elevat			
		ving a pitcher of thin			the head of bed, compliance			
		her bedside table. A			provision of thickened liquid administration of sliding sca			
		sitting next to the pitcher			insulin, application of pressi			
	of water.	nting next to the pitener			relieving devices and follow			
	or water.				physician orders. <i>To ensure</i>	-		
	During on interv	iew with the ADON at			deficient practice does not r	ecur,		
					the monitoring system			
		licated the resident			established is:A Performand Improvement indicator has			
		water at her bedside			established which evaluates			
		n nectar thickened fluids			compliance with following	-		
	only.				physician's orders to include			
					elevation of the head of bed	•		
		ecord was reviewed on			compliance with provision o			
	5/18/11 at 8:50 a	.m. The resident's record			thickened liquids, administration of sliding scale insulin, appl			
	indicated diagno	ses of, but not limited to;			of pressure relieving device			
	right cerebral va	scular accident, dementia,			The Director of Nursing or			
	osteoporosis and				designee will complete indic	ator		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474			LDING	NSTRUCTION  00	(X3) DATE COMPL	ETED		
NAME OF PROVIDER OR SUPPLIER  BREMEN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  316 WOODIES LANE BREMEN, IN46506					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE	
	reviewed at this diet with Nectar	der, dated 1/27/10, time indicated "Pureed Thick Liquids." The sheet also indicated t."			weekly for the first month, monthly for the first quarter quarterly thereafter with rest forwarded to the facility performance improvement committee for further evalua or resolution. POC Date: 6/2	ults		
	3. Resident # 11's record was reviewed on 5/17/11 at 3:20 p.m. The Resident's record indicated diagnoses of, but not limited to; paralysis of the lower limbs, pressure ulcers, depression, and diabetes.							
	A physician's order, dated 4/8/11, indicated "Novolog Sliding Scale before meals. Novolog 100u/ ml (milliliter), < 0-100 = 20 units"							
	administration re 5/12/11 at 6:00 a glucose level wa ordered by the p resident was to r Novolog insulin	MAR (medication ecord) indicated on a.m. the resident's blood is 95. The sliding scale hysician, indicated the eceive 20 units of the a. The MAR indicated the deceive 20 units instead of the deceive 20 units instead of the						
	5/17/11 at 3:30 p on the resident's MAR and indica given.	iew with LPN # 3 on o.m., regarding the error MAR, she reviewed the ted the wrong dose was record was reviewed on						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			COM	(X3) DATE SURVEY  COMPLETED		
		B. WIN			05/24	/2011		
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE ODIES LANE	Е		
BREMEN	NHEALTH CARE C	ENTER		BREME	N, IN46506			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	5-19-2011 at 2:00 p.m. Resident #3's			•				
	diagnoses includ Diabetes Mellitu	e, but were not limited to, s, dementia, history of a ure, and depression.						
	stated, "Sliding 0-150= 0 units, 1 201-250= 6 units 301-350= 12 uni	s, 251-300= 9 units, ts, 351-400= 14 units, sugar less than 60 or						
	The "Medication Record" on 5/1/11 at 4:00 p.m., Resident #3's blood sugar was 200 and 9 units were given.							
		Record" on 5/12/11 at ent #3's blood sugar was in coverage was						
		Record" on 5/13/11 at ent #3's blood sugar was in coverage was						
		Record" on 5/13/11 at ent #3's blood sugar was were given.						
	6:00 p.m., Reside	Record" on 3/21/11 at ent #3's blood sugar was coverage was given.						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE		
			A. BUILDING				COMPLETED 05/24/2011
		100 17 1	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/2 1/2	
NAME OF F	PROVIDER OR SUPPLIER	R			OODIES LANE		
BREMEN HEALTH CARE CENTER				1	:N, IN46506		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		7					
		Record" on 3/24/11 at					
	* '	ent #3's blood sugar was					
	not taken and no	coverage was given.					
	The "Medication	Record" on 3/25/11 at					
	12:00 p.m., Resi	dent #3's blood sugar was					
	•	coverage was given.					
	The "Medication	Record" for the month					
		ited, "Diltiazem (a					
	-	to treat an irregular heart					
		Give 1 tablet by mouth					
		Ox (diagnosis): AFIB					
	_	n) *Hold if SBP (systolic					
	`	<90 [less than 90]"					
	blood pressure)	<50 [1035 than 50]					
	The "Physician (	Orders" dated 4/1/11					
		stated, "Diltiazem 60					
	_	et by mouth every 6					
	_	B *Hold if SBP (systolic					
	blood pressure)	` •					
	F						
	The "Medication	Record" lacked					
	documentation tl	hat Resident #3's blood					
	pressure was tak	en twice during the					
	_	nd no medication was					
	administered.						
	The "Medication	Record" for the month					
	of May 2011 stat	ted, "Oxygen per nasal					
	cannula to keep	oxygen saturation above					
	90% may wean a	as tolerated"					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474			LDING	NSTRUCTION  00	(X3) DATE COMP 05/24/2	LETED	
	PROVIDER OR SUPPLIER		•	316 WC	ADDRESS, CITY, STATE, ZIP CODE DODIES LANE EN, IN46506	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
IAU	The "Physician's through 5/31/11 nasal cannula to	Orders" dated 5/1/11 stated, "Oxygen per keep oxygen saturation y wean as tolerated"		IAG	D. (Cl. (C.)		DATE
	documentation t	hat a biox (blood oxygen 4 times during the month					
	5/16/11 at 10:15 diagnoses includ	's record was reviewed on a.m. Resident #27's le, but were not limited to, driplegia, dysphagia, and					
	was observed wi	34 a.m., Resident #27 th the head of the bed s while tube feeding was an hour.					
	ADON (Assistan 5/16/11 at 6:34 a was verified belo	s conducted with the nt Director of Nursing) on a.m. The head of the bed ow 30 degrees. Also he head of the bed should and 45 degrees.					
	reviewed on 5/10 indicated diagno diabetes mellitus	ecord for Resident # 80 6/11 at 10:45 A.M., ses of, but not limited to, s, acute kidney failure, pathy, and bilateral heel					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL	ETED
		155474	B. WIN			05/24/2	011
NAME OF F	PROVIDER OR SUPPLIER		-	1	ADDRESS, CITY, STATE, ZIP CODE		
BREMEN	I HEALTH CARE CE	ENTER		1	DODIES LANE EN, IN46506		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	and 3/7/11, updat "Keep heels a f cushion to bed'						
ı	•	on of the wounds on					
		.M., with LPN # 9, as resting in bed with the					
		under her thighs and her					
	*	LPN # 9 indicated the					
	Residents heels a	re to be up off the bed					
	but the cushion s	lides around and doesn't					
	stay in place.						
	indicated, "Glu dailySliding Sc 60-150=0 units, 1 201-250=8 units, 301-350=14 units	ale. If blood sugar					
	(Medication Adn	bruary 2011, MAR ninistration Record) nts # 80's blood sugars as					
	record lacked doo	.M 296. The clinical cumentation of coverage. a.M 208. The clinical 4 units given.					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		(X2) MU A. BUII B. WIN	DING	NSTRUCTION  00	(X3) DATE COMPI <b>05/24/2</b>	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DODIES LANE N, IN46506		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		arch 2011, MAR sugars as follows:					
		M 201. The clinical					
	record indicated	_					
		P.M 274. The clinical					
		no coverage given.					
		P.M 338. The clinical					
	record indicated	16 units given.					
	Review of the A	pril 2011, MAR indicated					
	blood sugars as f						
	olood sugais as i	.0110 W.D.					
	4/9/11 at 4:00 P.	M unable to read result.					
	The clinical reco	rd indicated 12 units					
	given.						
	4/12/11 at 4:00 F	P.M 243. The clinical					
	record lacked do	cumentation of coverage.					
	Review of the M blood sugars as f	ay 2011, MAR indicated follows:					
		A.M 178. The clinical cumentation of coverage.					
	2011, April 2011 2011, MAR indi	ebruary 2011, March , and May 1 through 17, cated, Resident # 80 et sliding scale coverage ns.					
		Care Plan, dated 5/19/11, dication as ordered. See rs"					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474			(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE S COMPL <b>05/24/2</b>	ETED
	ROVIDER OR SUPPLIER		•	316 WO	DDRESS, CITY, STATE, ZIP CODE ODIES LANE N, IN46506		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
F0309 SS=G	ADON (Assistant indicated she was for one blood sugscale coverage for 3.1-35(g)(2)  Each resident must must provide their to attain or maintal physical, mental, a in accordance with assessment and placed on observation record review, the provide effective control or lessen when moved, or her bed related to right hip for 1 of pain in a sample.  Resident: #40  Findings include  Resident #40's clareviewed on 5/16 indicated diagnost history of sacral/osteoporosis, maintained.	ation, interview, and e facility failed to pain management to a resident's severe pain turned and positioned in an irreparable fractured 11 residents reviewed for of 19.  inical record was 5/11 at 2:35 P.M., and ses of, but not limited to:	F0	309	F-309 It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with the practice, the following has been affected by the deficient practice was:Resident #40 received her scheduled norce 14:50 on 5/16/11. Resident # was reassessed for pain conduring the course of the surve with new physician orders obtained. The corrective active taken for those residents have the potential to be affected by same deficient practice is:A passessment was completed for residents in the facility. Care plans, physician orders and interventions were updated a necessary. The measures is the survey of the surv	is een aken ve t o at ti40 trol ey on ving y the oain for all	06/23/2011

li '			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155474	B. WIN			05/24/2	011
NAME OF I	PROVIDER OR SUPPLIEF	3	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
				316 WC	OODIES LANE		
BREMEN	N HEALTH CARE C	ENTER		BREME	N, IN46506		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ER'S PLAN OF CORRECTION	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	P.M., indicated, (Hydrocodone 5: APAP [acetamin (one) PO (by mo times/day) 6 A.M Keep PRN (as no 4 hours) for brea Resident #40 als	mg [milligram]-325 mg ophen]) tablets. Give i outh) TID (three M., 2 P.M., 10 P.M. eeded) Norco order (every akthrough pain" o had an order for 650 mg. TID and			into place and a systemic chimade to ensure the deficient practice does not recur is: Licensed nursing staff has be in-serviced on assessing and treatment of pain. Other faci staff has been in-serviced to notify the charge nurse for complaints of pain during the provision of care or throughouthe course of the day. To ensure the deficient practice not recur, the monitoring systematical entire indicator has been always and i	een d lity does tem e een	
	unit on 5/16/11 a accompanied by was observed lyi resident was grir was having pain indicated the res	ur of the locked dementia at 7:00 A.M., while LPN # 2, Resident #40 ing in her bed. The macing and indicated she at the time. LPN #2 ident had a recent fall and parable fractured right	compliance with monitoring and treatment of pain. The Director of Nursing or designee will complete indicator weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/23/11				
	12:25 P.M., scre she was pulled u and CNA #5. Do #2 at the time, sh some of the PRN Review of Resid Administration I	as observed on 5/16/11 at aming out in pain when p in her bed by LPN #2 uring interview with LPN ne stated, "We need to get N (Norco) in her."  Lent #40's Medication Record (MAR) on 5/16/11 adicated she had been					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  ND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE SI COMPLE	
		155474	A. BUI B. WIN	LDING IG		05/24/20	11
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	OODIES LANE		
	N HEALTH CARE C			L	EN, IN46506		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAO		Norco (narcotic pain	+	IAG			DATE
		g. (milligram) at 6:00					
	1	dose). She received 650					
	`	ophen (over the counter					
	1 -	00 mg. of Tramadol					
	1	in medication) at 8:00					
	A.M.	in inedication) at 8.00					
	A.WI.						
	LPN #2 medicate	ed Resident #40 with the					
	PRN (as needed)	Norco 5 mg. at 12:30					
	P.M., for her bre	<u> </u>					
		50 P.M., Resident #40					
	indicated in an ir	nterview she was having					
	"bad" pain in her	right hip and was fearful					
	of being moved i	in bed. Review of her					
		e, indicated she had not					
	been given her 2	:00 P.M. scheduled dose					
		d, she received another					
	dose of the 650 r	ng. acetaminophen and					
		ramadol at 2:00 P.M. She					
	did not receive th	ne PRN dose of Norco					
	until 4:00 P.M.	The resident had received					
	a PRN dose at 12	2:30 p.m. of the Norco.					
	A "Resident Ever	nt Report Worksheet,"					
		icated, "Event date:					
	5/3/11Event Na						
		Event Adverse effect:					
		) hipPain R hipRes					
		g in lounge area on alz					
	l ` ′   ′	. QMA (Qualified					
	l ` ′	) in a room with another					
		office on phone. Res.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		(X2) M A. BUII B. WIN	LDING	NSTRUCTION  00	CON	TE SURVEY  MPLETED  1/2011	
	PROVIDER OR SUPPLIER		p. wilv	STREET A	DDRESS, CITY, STATE, ZIP CO ODIES LANE N, IN46506	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	to amb (ambulate	e). Nurse saw this and ., but she fell on R side each her."					
	indicated, "Res. v Disengaged her M Observed standing go to rm (room). (and) fell to floor -Res. (resident) in board et (and) tra	m) for eval (evaluation)					
	A.M., indicated,	fracture of the proximal					
	1:03 P.M., indica specialist, Dr. (N stated to dtr. (dau not feasible d/t (dau (Resident #40's)	Note, dated 5/17/11 at ted, "Was seen by ame), 5/12/11. Physician ighter) that surgery was due to) deterioration of bones (this was told to today during visit to her					
	the following:	f Nurse's Notes indicated  .MUp with assist of one eals and BR					

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION 00	(X3) DATE COMPI	
		155474	A. BUI B. WIN	LDING		05/24/2	011
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	OODIES LANE		
	N HEALTH CARE CE			BREME	EN, IN46506		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·	-	IAG	BERGEROLY		DATE
	l ` ′	'11 at 8:30 P.MRes. n, grabbing R hip. Norco					
	given after reposi	, C C I					
	1 ~ .	o's (complains of) pain					
		hange padsagitated					
		urning. Pain #8-#9 (pain					
		0 being 'worst pain that					
		) when moving5-5-11					
		ledicated for pain #9 at					
		orcoin severe pain					
	when T & R (turn	•					
	`	.6-11 at 9:00 P.M.					
	l * ′	ly grabbing at staff					
		re pain whenever being T					
		ing HOB (head of bed) up					
	_	at 10:50 P.MT & R q					
		eries out loudly, grabbing					
	l ` • ′	othing-severe pain when					
		8/11 at 2:00 P.Mmuch					
	discomfort when						
		1 between routine Norco					
	dose5/8/11 at 8						
		in severe pain when					
	l '	in meds5/9/11 at 3:53					
	1	show s/s (signs and					
		in when moved. PRN					
		n5/9/11 at 1:45 P.M.					
	1	ed yells out at staff,					
		5/9/11 at 6:19 P.M.					
		P.M. care, routine and					
	*	5/10/11 at 2:00 P.M.					
		no pain on routine pain					
		2:00 P.Mmuch					
		turned5/11/11 at 9:30					
	disconnion when	tarriou			<u> </u>		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4EZC11

Facility ID:

000506

If continuation sheet

Page 80 of 162

NAME OF PROVIDER OR SUPPLIER  BREMEN HEALTH CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  P.Msevere pain when care is being given5/12/11 at 3:50 P.Mcont. in pain when T & R5/12/11 at 7:50 P.MRepositioned and changed and the c/o's of Rt (right) hip pain with care5/13/11 at 2:25 P.MRes, yell (sic) out some in pain when turned or repositioned by ii (2) assist5/14/11 at 6:00 A.MResists being turned due to increased Rt leg pain with movement5/14/11 at 9:22 P.Msevere pain when T & R (moaning, crying out, tearing at clothing)5/15/11 at 7:30 P.Mnecomfortable when T & R5/16/11 at 2:50 P.MRoutine pain meds as ord. (ordered), during repositioning after lunch res, pulled up in bed, yelling out, "My leg, No No," was given PRN med at 12:30 with lunch then routine pain meds at 14:50 (2:50 P.M.), during incont. (incontinence) care et repositioning seemed much more	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474		A. BUI	LDING	NSTRUCTION 00	COM	TE SURVEY MPLETED 4/2011	
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG  P.Msevere pain when care is being given5/12/11 at 3:50 P.Mcont. in pain when T & R5/12/11 at 7:50 P.MMedicated for pain #9 at 1800 (6:00 P.M.) with some relief obtained-cont. to moan-cry out, tear at staff's clothing when being T & R5/13/11 at 6:30 A.MRepositioned and changed and the c/o's of Rt (right) hip pain with care5/13/11 at 2:25 P.MRes. yell (sic) out some in pain when turned or repositioned by ii (2) assist5/14/11 at 6:00 A.MResits being turned due to increased Rt leg pain with movement5/14/11 at 9:22 P.Msevere pain when T & R (moaning, crying out, tearing at clothing)5/15/11 at 7:30 P.Muncomfortable when T & R5/16/11 at 2:50 P.MRoutine pain meds as ord. (ordered), during repositioning after lunch res. pulled up in bed, yelling out, "My leg, No No," was given PRN med at 12:30 with lunch then routine pain meds at 1400 (2:00 P.M.) et Norco routine at 1450 (2:50 P.M.), during incont. (incontinence) care et				B. WIN	STREET A	ODIES LANE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REQULATORY) OR LSC IDENTIFYING INFORMATION)  P.Msevere pain when care is being given5/12/11 at 3:50 P.Mcont. in pain when T & R5/12/11 at 7:50 P.M. Medicated for pain #9 at 1800 (6:00 P.M.) with some relief obtained-cont. to moan-cry out, tear at staff's clothing when being T & R5/13/11 at 6:30 A.M. Repositioned and changed and the c/o's of Rt (right) hip pain with care5/13/11 at 2:25 P.MRes, yell (sic) out some in pain when turned or repositioned by ii (2) assist5/14/11 at 6:00 A.MResists being turned due to increased Rt leg pain with movement5/14/11 at 9:22 P.M. severe pain when T & R (moaning, crying out, tearing at clothing)5/15/11 at 7:30 P.Muncomfortable when T & R5/16/11 at 2:50 P.MRoutine pain meds as ord. (ordered), during repositioning after lunch res. pulled up in bed, yelling out, "My leg, No No," was given PRN med at 12:30 with lunch then routine pain meds at 1400 (2:00 P.M.) during incont. (incontinence) care et	BREMEN				BREME	N, IN46506		
given5/12/11 at 3:50 P.Mcont. in pain when T & R5/12/11 at 7:50 P.MMedicated for pain #9 at 1800 (6:00 P.M.) with some relief obtained-cont. to moan-cry out, tear at staff's clothing when being T & R5/13/11 at 6:30 A.MRepositioned and changed and the c/o's of Rt (right) hip pain with care5/13/11 at 2:25 P.MRes. yell (sic) out some in pain when turned or repositioned by ii (2) assist5/14/11 at 6:00 A.MResists being turned due to increased Rt leg pain with movement5/14/11 at 9:22 P.Msevere pain when T & R (moaning, crying out, tearing at clothing)5/15/11 at 7:30 P.Muncomfortable when T & R5/16/11 at 2:50 P.MRoutine pain meds as ord. (ordered), during repositioning after lunch res. pulled up in bed, yelling out, "My leg, No No," was given PRN med at 12:30 with lunch then routine pain meds at 1400 (2:00 P.M.) et Norco routine at 1450 (2:50 P.M.), during incont. (incontinence) care et	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	COMPLETION
comfortable5/17/11 at 2:00 A.MYelling out with pain" The Nurse's Notes lacked documentation to indicate the physician had been notified of the ongoing pain.  During interview with Resident #40 on 5/17/11 at 9:10 A.M., she indicated she		given5/12/11 a pain when T & RMedicated for P.M.) with some moan-cry out, tea being T & R5/1Repositioned a of Rt (right) hip p 2:25 P.MRes. pain when turned assist5/14/11 at being turned due with movementsevere pain when turned assist5/16/11 at 2:5 meds as ord. (orderepositioning after bed, yelling out, given PRN med a routine pain med Norco routine at incont. (inconting repositioning see comfortable5/1Yelling out with Notes lacked door the physician had ongoing pain.	t 3:50 P.Mcont. in 25/12/11 at 7:50 P.M. pain #9 at 1800 (6:00 relief obtained-cont. to ar at staff's clothing when 13/11 at 6:30 A.M. and changed and the c/o's pain with care5/13/11 at yell (sic) out some in d or repositioned by ii (2) t 6:00 A.MResists to increased Rt leg pain5/14/11 at 9:22 P.M. hen T & R (moaning, ag at clothing)5/15/11 at comfortable when T & 50 P.MRoutine pain dered), during er lunch res. pulled up in "My leg, No No," was at 12:30 with lunch then s at 1400 (2:00 P.M.) et 1450 (2:50 P.M.), during ence) care et emed much more 7/11 at 2:00 A.M. th pain" The Nurse's cumentation to indicate d been notified of the					

000506

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474			LDING	00	COMPLETED
		155474	B. WIN			05/24/2011
NAME OF I	PROVIDER OR SUPPLIER		'	STREET A	ADDRESS, CITY, STATE, ZIP CODE	!
					OODIES LANE	
BREMEN	N HEALTH CARE C	ENTER		BREME	EN, IN46506	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	• • •	in her right hip, but was				
		r pain on the 0-10 pain				
		indicated a scheduled				
	Norco 5 mg. had	been given to Resident				
	#40 at 6:00 A.M.	., but did not control her				
	pain.					
	Review of the Ni	urse's Notes indicated,				
	"5/17/11 at 3:45	P.MYells out when				
	moved5/17/11	at 9:45 P.MResident				
	has lots of pain v	vith any				
	movement5/18	/11 at 10:00 A.MRes.				
	c/o pain R hip. I	Pain when pulled up in				
	bed with 2 assist	. Dr. (Name) called with				
	report et notified	. New order received"				
	Resident #40's M	IAR indicated she				
	received the PRN	N (as needed) Norco for				
	breakthrough pai	in on the following dates				
	• •	es (x's) on 5/04/11: 12:30				
		o routine Norco given on				
		5/05/11: 6:00 P.M.; 3 x's				
	· **	A.M., 10:00 A.M., and				
		n 5/07/11: 10:15 A.M.; 3				
	· ·	:00 A.M., 10:00 A.M.,				
		x on 5/09/11: 2:00 A.M.;				
	1	2:00 P.M.; 1 x on 5/13/11:				
		n 5/14/11: 6:00 P.M.; 2				
	· ·	2:30 P.M. and 4:00 P.M.;				
		2:00 A.M. Resident #40				
		of 17 doses of the PRN				
		through pain) over the 15				
	· ·	- · ·				
	uay period of 5/0	04/11 through 5/18/11.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155474		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  00	li i	e survey pleted /2011	
	PROVIDER OR SUPPLIER		<b>P</b> . W. 2.	STREET A	DDRESS, CITY, STATE, ZIP CO ODIES LANE N, IN46506	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	The Director of I indicated in an in 11:15 A.M., a Phobtained for Morfast-acting pain in administered every breakthrough pair wasn't controllin using the PRN V doing the job. We the morphine to are going to report minutes to see her A Physician Ordindicated, "Morp 20mg/ml (millilis sublingual Q 2 h breakthrough pair 5/18/11 at 11:35 D.O.N. were obstincentinence carractors the bed, gright femur (larg Resident #40 tow D.O.N. pushed of to aid in turning Resident #40 more scream out in pair CNA #12 and CI	Nursing (D.O.N.) Interview on 5/18/11 at hysician's Order had been rephine Sulfate (a strong, harcotic) 5 mg. to be ery two hours for in. "The Vicodin (Norco) g her pain. We were ficodin, but it wasn't the just gave her a dose of help control her pain. We estition her in about 30-35 low she does."  Ler, dated 5/18/11, whine Sulfate Suspension there) give 5 mg. PO or res (hours) for in."  London of Resident #40 on A.M., CNA #15 and the erved providing the end of the control her pain. We still the erved providing the end of the control her pain. We still the erved providing the end of the pain the erved providing the end of the pain the					

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	AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155474		(X2) MU A. BUIL B. WING	DING	NSTRUCTION  00	(X3) DATE COMPI 05/24/2	LETED
	PROVIDER OR SUPPLIER		B. WINC	STREET A	DODIES LANE N, IN46506		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	1	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	3	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		t 1:10 P.M. Resident #40					
		e head of her bed was					
		position and screamed					
	-	her legs were touched.					
		s rolled onto her right hip					
		vashed. She screamed out					
	*	is rolled. CNA #14 then					
		ne bed and pulled on					
		ght thigh while CNA #12					
		ght hip to turn her over					
	•	Resident #40 screamed					
		elled "My leg. My leg.					
	No. No."						
	During interview	with the D.O.N. on					
	_	P.M., she indicated staff					
		l Resident #40's pain, but					
		snow" her. When queried					
		ad not been notified of					
	-	D.O.N. indicated she					
		sult a "palliative care"					
		uate Resident #40 and					
		t to control her pain.					
	2300000 0000000000000000000000000000000						
	Resident #40's C	are Plan, dated 5/10/11,					
		em: Fracture: Right Hip					
		oal: Resident will have no					
		d minimal pain from hip					
	-	ch:Administer pain					
		dered and check for					
	effectiveness and	I notify doctor if resident					
	not getting relief	-					
	A facility policy	titled "Pain					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 05/24/2011	
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE DODIES LANE EN, IN46506		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F0312 SS=E	"Policy: The center each resident with potential for pain the highest praction and functioning to management6. orientation and of correct misconce about pain. Train is not limited to: assessing pain, refindings, and more assessing pain, refindings receit of maintain good repersonal and oral Based on observer record review, the residents needing grooming and perthat assistance reformed with factlothing for 3 of 19 (Resident # 58 residents in a sup (Residents: #20,	The center provides ngoing staff education to ptions, myths, and biases ing my (sic) include, butb. recognizing and eporting and documenting nitoring interventions"  unable to carry out activities wes the necessary services putrition, grooming, and hygiene. ations, interview and e facility failed to ensure grassistance with resonal hygiene received lated to residents cial hair and urine soaked 3 resident in a sample of 3, #35, #3) and for 4 of 4 pplemental sample of 30. #51, #49 and #60.)	F0312	F-312  It is the practice of this facility ensure the highest quality of is afforded our residents. Consistent with this practice following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was:Resident's #20, #51 and facial hair grooming issues were solved during the course of survey. Resident #60's preferences related to retain facial hair will be honored. Resident #35, #49, #3 were provided with incontinence of	the	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155474 05/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 316 WOODIES LANE BREMEN HEALTH CARE CENTER BREMEN, IN46506 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 5/16/11 at 10:20 a.m. The Resident's at the time of observation. The corrective action taken for those record indicated diagnoses of, but not residents having the potential to limited to: dementia with behaviors, hip be affected by the same deficient fracture, osteoporosis, kyphosis and practice is: The facility validated seborrhea dermatitis. that residents are free of unwanted facial hair. All residents are being monitored for During a tour of the dining room on appropriate and timely 5/16/11 at 8:30 a.m., an observation was incontinence care. The measures made of Resident # 58 sitting at a table put into place and a systemic change made to ensure the with other resident's. Resident # 58 was deficient practice does not recur observed to have long curly facial hair on is: All nursing staff has been her upper lip and chin. in-serviced related to grooming to include ensuring residents are free of unwanted facial hair and Review of Resident # 58's quarterly MDS provision of incontinence care. assessment, dated 5/2/11, indicated she To ensure the deficient practice needed limited assistance with one staff does not recur, the monitoring assistance for hygiene and bathing. system established is:A Performance Improvement indicator has been established The Resident's plan of care dated 2/7/11, which evaluates compliance with indicated "Requires physical assist with grooming/facial hair. The ADL's...Approach: Set up equipment for Director of Nursing or designee daily hygiene and provide cues for upper will complete indicator weekly for the first month, monthly for the body tasks. Assist after she has tried...." first quarter and quarterly thereafter with results forwarded 2. Resident # 20's record was reviewed on to the facility performance improvement committee for 5/18/11 at 4:45 p.m. The record indicated further evaluation or diagnoses of, but not limited to; resolution. POC Date: 6/23/11 Alzheimer's disease, hypertension, and depressive disorder. During a tour of the facility on 5/16/11 at 7:00 a.m., Resident # 20 was observed up and dressed. His face was observed to have several days of facial hair growth.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		(X2) M A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE S COMPL <b>05/24/2</b>	ETED	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	p. ((n)	STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	N HEALTH CARE C			1	OODIES LANE EN, IN46506		
(X4) ID		TATEMENT OF DEFICIENCIES		ID		(X5)	
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	Resident # 20's p 5/10/11 indicated related to;dem selfApproach daily" The Re plan of care to ac shaving needs.  During an interv ADON (assistan indicated the reshimself but need indicated limited to; diaber peripheral vasculant depression.  During a tour of 5/16/11 at 8:30 at made of Resident table with other was made of her heavy growth of The Resident's quality assessment of the resident's quality assessment indicated the reshimself.	plan of care updated d "Discharge not feasible mentia, unable to care for provide care and services sident's record lacked a ddress his grooming and  iew at that time with the t director of nursing) she ident could do much for ed cueing at times. She ident was very confused er risk.  's record was reviewed 5 p.m. The resident's diagnoses of, but not tes, renal failure, lar disease, hypertension,  the dining room on m.m., an observation was at # 51 sitting at a dining residents. Observation chin covered with a					
	assistance with t	wo staff assistance with					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPL		
THISTERN	or conduction	155474	A. BUI			05/24/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF F	PROVIDER OR SUPPLIER			1	OODIES LANE		
BREMEN	N HEALTH CARE CE	ENTER		BREME	N, IN46506		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAG	personal hygiene		-	IAU	,		DATE
	personal hygiene	•					
	indicated " Probleassist of staff for living)" The Failed to indicate from chin hair.  4. Resident # 60 on 5/18/11 at 5:4 record indicated limited to; obstru	an of care, dated 5/16/11, em; Requires physical ADL's (activities of daily Resident's plan of care to keep her face free  's record was reviewed 0 p.m. The Resident's diagnoses of, but not active hydrocephalus;					
		hypertension, impaired nd obsessive compulsive					
	5/16/11 at 8:30 a made of Resident table with other r was made of the	the dining room on .m., an observation was t # 60 sitting at a dining residents. Observation resident to have a large hair. Long curly hairs I on her chin was					
	indicated "Proble with increased fo confusion, needin prompts" A ar indicated "Proble	ng reminders and re plan, dated 3/2/11, em; discharge not ach indicated to provide					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	CON	TE SURVEY MPLETED 1/2011	
	PROVIDER OR SUPPLIER			STREET A	ODDIES LANE N, IN46506	CODE	
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	reviewed on 5/19 indicated diagno Alzheimer's dem disturbance, bipo delusional disord During initial to 5/16/11 at 7:00 Å by LPN #2, she is had behaviors, wand a two person Resident #35 was 11:55 A.M., sitticentral living are His sweat pants was incontinent ourine.  During observation administration paragram of the restroom, immediately off two visitors having bathroom commens was seated with the seates of the restroom of the restroom of the restroom of the restroom commens was seated with the seates of the restroom of the restroom commens was seated with the seates of the restroom of the restroom commens was seated with the seates of the restroom commens was seated with the restroom commens was seated with the restroom commens was seated with the restroom comm	ar of the facility on A.M., while accompanied indicated Resident #35 was confused, incontinent,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		155474	A. BUI B. WIN	LDING IG		05/24/2	011
			D. WII		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF I	PROVIDER OR SUPPLIER			316 WC	OODIES LANE		
	I HEALTH CARE C			BREME	N, IN46506		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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IAG		the recliner in the central	<u> </u>	IAG			DATE
	living area of the dementia unit. He had his socks and shoes off and his bare feet						
		e left side of the footrest.					
	His pants were so						
	This pants were so	oned with drine.					
	During interview	with Social					
	Service/Director	on 5/18/11 at 4:35 P.M.,					
	she indicated she	could not toilet Resident					
	#35 by herself ar	nd the other staff person					
	was busy with ot	her residents.					
	6. During initial	tour of the dementia unit					
	on 5/16/11 at 7:0	0 A.M., while being					
	accompanied by	LPN #2, Resident #49					
	was observed in	her room. She was					
	identified as bein	g incontinent Her night					
	clothes and all of	f her bed linens were					
	urine soaked, at t	the time, and CNA #5					
	indicated Resider	nt #49 was to be					
	showered. CNA:	#5 was observed					
	escorting Residen	nt #49 for her shower at					
	7:40 A.M.						
		s observed seated at the					
	_	e on 5/16/11 at 11:45					
	_	rine odor surrounded her.					
		N #2 assisted her to the					
		acks had a large wet area					
		ndicating she had been					
	incontinent of a l	arge amount of urine.					
	I DNI //2 : 1'	1 in an interest of the					
		d in an interview on					
	5/16/11 at 11:50	A.M., that many of the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155474	B. WING		05/24/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
	LUEALTH CARE OF	INTED		DODIES LANE	
	I HEALTH CARE C		BREIVIE	EN, IN46506	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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IAG			IAG	BERGEROLY	DATE
		unit were incontinent and			
		e with toileting. She			
		there was a limited			
		on the unit and it made it			
	•	de the necessary care for			
	residents requirir	ng two person assist.			
	7. D	clinical record was			
		9/11 at 2:00 P.M., and			
	_	ses of, but not limited to:			
dementia, history of right femur fracture,					
	depression, and o	constipation.			
	Pacident #3 was	observed sitting in her			
		ss from the nurse's station			
		5/16/11. She smelled of a			
	_	The odor was brought			
	to the attention o				
	-	Resident #3 to her			
	room.				
	CNA #20 and I I	PN #25 were observed			
		dent #3 to her bed via a			
	_	t 4:20 P.M., (5/16/11).			
		cks were wet with urine			
		nce brief was dry upon			
		rther investigation of the			
	_	•			
		dicated a large pool of			
		her pressure reducing			
		heel chair. The top and			
		shion were wet with			
	urine.				
	During interview	with LPN #25, at the			
	During micrylew	with Li is $\pi 23$ , at the			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 05/24/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  316 WOODIES LANE BREMEN, IN46506					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	neglected to prop	vation, she indicated staff perly clean the wheel ling her with previous e.						
	Summary" dated of Care: Nursing The Resident's re	are Plan Conference 3/8/11, indicated "Plan : Supervision ADL's" ecord lacked a plan of eathing and grooming						
	3.1-38(a)(3)(A) 3.1-38(a)(3)(B) 3.1-38(a)(3)(C) 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)							
F0314 SS=G	a resident, the factoresident who enterpressure sores do sores unless the indemonstrates that a resident having necessary treatment healing, prevent in sores from develobased on observations.	ation, interview, and e facility failed to	F0314	<b>F-314</b> It is the practice of this facilit	06/23/2011 y to			
	recurrent stage II	opment of multiple or pressure ulcers for 3 of 3 ed for pressure ulcers in a		ensure the highest quality of is afforded our residents. Consistent with this practice, following has been done: The corrective action taken for the residents found to have been	the e			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155474 05/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 316 WOODIES LANE BREMEN HEALTH CARE CENTER BREMEN, IN46506 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Residents: # 54, # 80, # 92 affected by the deficient practice was:Resident #80's right heel is now healed and the area to the Findings include: left heel has significantly decreased in size. The heelz up cushion has been amended to 1. The clinical record for Resident # 80 help stabilize the location in the reviewed on 5/16/11 at 10:45 A.M.. bed in order to maintain flotation indicated diagnoses of, but not limited to, of heels. Resident #54's area to diabetes mellitus, acute kidney failure, left buttocks is now stage II pressure ulcers, and peripheral healed. Resident #92's care plan has been updated to include neuropathy. preventative measures related to history of heel ulcers. The During initial tour on 5/16/11 at 6:35 corrective action taken for those A.M., accompanied by LPN # 16, she residents having the potential to be affected by the same deficient indicated that Resident #80 was a practice is: The facility has diabetic with open areas to both her heels. reviewed all care plans to ensure She indicated that she was using heel appropriate preventative cushions and heel boots and that she was measures are reflected for each resident indentified to be at risk. currently seeing a wound specialist. The care plans were revised as Resident # 80's readmission date was needed. A full facility review of 1/11/11 Braden Scale was conducted and all found to be current. The Resident # 80's initial MDS (Minimum measures put into place and a systemic change made to ensure Data Set), dated 1/21/11, indicated "...bed the deficient practice does not mobility...extensive assistance...one recur is: Nursing staff along with person physical assist...transfer...extensive therapy, activity staff, and department managers has been assistance...two person physical assist..." in-serviced on preventative measures including the proper A Resident Progress Note, dated 3/4/11 at placement of the heelz up 1200 (12:00 P.M.), indicated, "8 x 7 intact cushion/pillows to elevate heels of the bed. All licensed staff has blister to L (left) heel et. (and) bottom of been in-serviced on pressure foot. Bottom of foot purple in color. ulcer care plans and pressure Possible deep tissue injury. Dr. (Name) ulcer prevention care plans. To notified for tx. (treatment) request et. ensure the deficient practice does vitamin supplements...." not recur, the monitoring system

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4EZC11

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000506

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		A. BUI	LDING	NSTRUCTION 00	ľ	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CO DODIES LANE EN, IN46506		
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	A "Weekly Press Report", dated 3/2 "locationheel footdate of firs 3/3/11Size 8 x - Partial thickness epidermis &/or of Surrounding Wo blanches to toucl 2.8Unstageable &/or blanches to A Resident Progrounding to blanches to are it was noted area on the R (rigmeasuring 3.6 x (complaining of) PRN (as needed) medication) give (Medical Doctor requested. ADO Nursing) notified A "Weekly Press Report", dated 3/2 "locationheel observation 3/6/Stage/Depthskin loss involving dermisSkin Co WoundPink5	ure Ulcer Condition (4/11, indicated, 1 & bottom of L t observation 7Stage/DepthStage II s skin loss involving lermisSkin Color undBright red &/or n5/19/11Size 2.8 x eSkin ColorBright red touch"  ress Note, dated 3/6/11 at ), indicated, "During AM that res. (resident) has an ght) outer aspect of heel 3.0. Res. c/o pain if area was touched. Tylenol (pain n at this time. MD ) notified of area, tx. N (Assistant Director of 1. Therapy notified"  ure Ulcer Condition (6/11, indicated, 1 Rightdate of first 11Size 3.6 x Stage II - Partial thickness ing epidermis &/or			established is:A Performance with proper placement of heelz up cushions/pillows and care plans related to pulcers. The Director of designee will complet weekly for the first momonthly for the first quarterly thereafter we forwarded to the facility performance improve committee for further or resolution. POC Dates in the property of	or has been aduates er to monitor pressure of Nursing or the indicator onth, uarter and ith results ty ment evaluation	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474		LDING	NSTRUCTION  00	(X3) DATE COMP 05/24/2	LETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  316 WOODIES LANE BREMEN, IN46506				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	at 0820 (8:20 A.) nurse measured of (Name); stage II skin intact L hee 3.0 x skin intact. areas. No odor, of swelling noted botops of feetuse timesPreventatheels a float"  Review of a "Wo 3/10/11, indicate patient for wound both heels, the le These apparently spontaneously re noninvasive arter pressures"  A "Vascular Flow indicated, "Abs lower extremity. arterial perfusion healingAbsolut digits, which sug flow for wound healing of the Review of a "Nu Care," dated 4/16 had healing of the	ound Consult Note," dated d, "I was asked to see the d care due to blisters on fit worse than the right. Thave come up cently We will obtain rial studies with toe  V Study," dated 3/15/11, solute toe pressures right attention to the toe pressures adequate a for wound the toe pressuresleft foot gests adequate arterial					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155474	A. BUII		00	05/24/2	
		100474	B. WIN		DDDEGG CITY GTATE ZID CODE	00/24/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BREMEN	N HEALTH CARE CE	ENTER		1	EN, IN46506		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	pressure sores'	'					
		Note," dated 4/22/11,					
		patient's non-invasive					
	arterial studies ap	•					
	circulation to be	adequate for healing"					
	During observati	on of Resident # 80's					
	_	ulcers on 5/20/11 at 1:50					
	,	ncovered Resident # 80's					
	feet. The Heelz						
		esident's thighs. The					
		•					
		ring airboots which were					
	_	d. The right heel was					
		olor with no open area.					
		and appeared the size of a					
	quarter with a da	rk black center (eschar).					
	On 5/20/11 at 9:1	5 A.M., the ADON					
	indicated they are	e unsure why Resident #					
	80 developed pre	essure ulcers.					
		DATE OF THE STATE					
		PN # 9 on 5/20/11 at 1:50					
	· · · · · · · · · · · · · · · · · · ·	ed Resident # 80's heels					
		off the bed when she is					
		er indicated the Heelz up					
		ound and doesn't stay					
	under her legs.						
	A Care Plan init	iated 3/4/11, updated					
	1	d, "ProblemStage II					
		th possible deep tissue					
	_						
	injury L heel et. l						
	footApproach	. Keeps neers a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155474		(X2) M A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE S COMPL <b>05/24/2</b>	ETED	
	PROVIDER OR SUPPLIER			STREET A	ODDIES LANE N, IN46506		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	floatHeez (sic)	up cushion to bed"					
	updated 4/19/11, "ProblemSta deep tissue injur	an, initiated 3/7/11, indicated, ge II R heel with possible yApproachKeeps edHeez (sic) up cushion					
	5/18/11 at 8:50 a indicated diagno cerebral vascular	s record was reviewed on a.m. The Resident's record ses of, but not limited to; r accident with right entia, and osteoporosis.					
	a.m., with the AI of Nursing) rega condition, she in	iew on 5/16/11 at 7:00 DON (Assistant Director rding Resident # 54's skin dicated the resident had s or open areas and re.					
	developed a presher left buttocks. 4/16/11 at 6:50 a found with 0.1 c < (less than) 0.1 no c/o (complain (treatment) and t (weekly) until he	ecord indicated she sure ulcer on 4/16/11 on Nurses note, datedm., indicated "Resident m (centimeter) by 0.1 cm, cm D (depth). Open area ats of) Requested tx to be measured wkly ealed" The record 3/11 the pressure area was					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	r 1	ESURVEY	
THETETAL	or condection	155474	A. BUI			05/24/	
		100111	B. WIN		DDRESS, CITY, STATE, ZIP CODI		
NAME OF F	PROVIDER OR SUPPLIER				ODIES LANE		
BREMEN	I HEALTH CARE CI	ENTER		1	N, IN46506		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	AN OVER THE REAL PARTY OF GOARD CO.		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPF	LD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	OTRIATE	DATE
	7:34 a.m., indica by 0.5 cm area to buttocks. MD (m notified via fax a requested."  A care plan, date 4/5/11, indicated skin breakdown,	note dated 5/17/11 at ted "resident has a 0.6 to (sic) It (left) side of nedical doctor) was and tx (treatment)  d 3/15/10 and updated on "Problem: At risk for impaired mobility ean, dry and free of skin					
	Goal; Will be clean, dry and free of skin breakdownApproach; Assist to reposition frequently, (Resident) chooses not to lay down between meals, peri care						
	and moisture bar	· •					
		ernating air pressure					
	mattress on bed, W/C (wheelchair	pressure relief cushion in					
	4/5/11, indicated skin breakdown. 3/15/11 and upda "Problem: Signif 2010) Leaves 25 meals, at risk for hiatal hernia, dx:Notify RD (reg	d 3/15/10 and updated on "Problem: At risk for" A plan of care dated ated on 4/5/11, indicated ficant weight loss (March 5% or more uneaten most choking, dx (diagnosis) dysphagiaApproach: gistered dietitian) and MD of significant weight al labs, skin					
		uarterly MDS (minimum					

PRINTED: 06/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		A. BUI	LDING	NSTRUCTION  00	(X3) DATE ( COMPL <b>05/24/2</b>	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	R		1	OODIES LANE		
	N HEALTH CARE C			<u> </u>	N, IN46506		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	` `	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	COMPLETION DATE
1710		nent, dated March 3,	+	1110			DITTE
	·	she transferred with a					
	· ·	assistance of staff and					
		ir for mobility. The					
		total assistance for					
	bathing and dres						
		28.					
	May 2011's Mea	l Intake Record for					
	I -	dicated she refused many					
		the alternates. May 4th					
		the resident refused her					
	_	d the alternates. The					
	Resident's meal	intake for the month of					
	May was less that	an 25%. Nurses notes for					
	-	d documentation to					
	1 *	tian or the physician had					
		the resident not eating for					
	several days in a	<del>-</del>					
	Th	1					
		cord indicated the					
		l a note on 5/19/11 after a					
		eview. The dietitian's					
		licate the resident had an					
	open area.						
	3. Resident #92	record was reviewed on					
		5 p.m. Resident #92's					
		le, but were not limited to,					
	_	neral neuropathy, edema,					
	and hemiplegia.	1 3/					
	Resident #92 wa	s admitted to facility on					
	7/29/2008 and h	as used a power chair for					

000506

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	i i			<b>I</b>		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED		
		155474	B. WIN			05/24/2011		
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER	L		316 WC	OODIES LANE			
	NHEALTH CARE C	ENTER		BREME	EN, IN46506			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
	mobility.							
	The "Resident Pr	rogress Notes," dated						
	1/4/11 at 8:20 a.r	n., stated, "Res (resident)						
	was found c (wit	h) 2 new bruises this am						
	(morning), on ba	ck of heels bilaterally. R						
	l ` • • • • • • • • • • • • • • • • • •	asures 1.2 c.m. x 0.5						
	` ` '	ise measures 1 c.m. x 0.4						
	c.m"	iso measures i e.iii. A e. i						
	C.111							
	The "Weekly Dre	essure Ulcer Condition						
	*							
	Report," stated, "							
	observation 1/4/1							
	1/4/11stage 1	•						
	distinctwhite/g	ray non-variable tissue						
	&/or non-adhere	nt yellownecrotic						
	tissuenon visib	leexudate						
	amount1-none.	"						
	The "Weekly Pre	essure Ulcer Condition						
	Report," stated, "	'date 1/21/11stage 2						
	blister"							
	The "Physician's	Orders," dated 1/5/10						
	1	m to bilateral heels TID						
	l '	y) until healed"						
	(an co annos a da	<i>J , </i>						
	The "Comprehen	nsive Care Plan Report,"						
	_	1, indicated that Resident						
	#92 was, "At ri							
	· ·	l be clean, dry & free of						
		" There was no						
		egarding prevention or						
	treatment of the	bilateral heel pressure						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN		nstruction 00	(X3) DATE S COMPL	
		155474	B. WING			05/24/2	011
	PROVIDER OR SUPPLIER		31	16 WO	DDRESS, CITY, STATE, ZIP CODE ODIES LANE N, IN46506		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
IAG	sores.  An interview was 4:45 p.m. with L unable to find a corprevention or car LPN #3 indicated should be on the The policy titled. Prevention" date on 5/24/11 at 3:4 resident who enterpressure ulcers as ulcers does not does no	s conducted on 5/19/11 at PN #3. LPN #3 was care plan addressing to of heel pressure ulcers. If that the documentation chart.  "Pressure Ulcer of 4/28/09 was reviewed of p.m. stated, "Policy- A cers the center without and/or other non-pressure evelop pressure ulcers pressure ulcers, unless linical condition of they were unavoidable, des care and services to: revention of pressure at b. Promote the healing is that are present ation of infection to the		.g	DEFICIENCE		DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE S COMPL <b>05/24/2</b>	ETED	
	PROVIDER OR SUPPLIER		•	316 WO	DDRESS, CITY, STATE, ZIP CODE ODIES LANE N, IN46506		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F0322 SS=D	a resident, the factoresident who is fedgastrostomy tube treatment and servo pneumonia, diarrh metabolic abnormasal-pharyngeal possible, normal ed Based on observative record review, the resident's bodies degrees to protect complications which feedings. This does not be a complication of the feedings. This does not be a complication of the feedings of the feedings included the feedings included the feedings included the feeding was observed with below thirty degree to feeding was an interview was a controlled the feeding was an interview was a controlled to the feeding was a controlled the feeding was an interview was a controlled to the feeding was an interview was a controlled to the feeding was a controlled to the feeding was an interview was a controlled to the feeding was a controlled to the feeding was an interview was a controlled to the feeding was a controlled to the feedi	ating skills. ation, interview, and e facility failed to ensure were kept elevated at 30 et residents from potential mile receiving gastric tube efficient practice affected in a sample of 19 and 1 of upplemental sample of et feedings. (Resident	F0	322	F-322  It is the practice of this facility ensure the highest quality of is afforded our residents.  Consistent with this practice, following has been done: The corrective action taken for the residents found to have been affected by the deficient practives: Resident's #10, #27 and were immediately repositioned per facility policy for residents receiving gastric feedings by elevating the head of bed at a to 45 degree angle and ensus appropriate resident positional the bed. The corrective active taken for those residents have the potential to be affected by same deficient practice is: Nother residents were found to affected by this practice as nother residents in the center receive gastric feedings. The measures put into place and systemic change made to enthe deficient practice does not recur is: Nursing staff have be in-serviced related to the faci policy for residents receiving gastric feedings to include maintaining the bed at 30-45	the ee a strice d #28 ed as s ring in on ring be o be a sure of een een een een een een een een een ee	06/23/2011

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STATEMEN	ENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTI			STRUCTION (X3) DATE S		SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155474	B. WIN			05/24/2	011
		<u> </u>	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	Ь	
NAME OF	PROVIDER OR SUPPLIE	R		1	OODIES LANE		
RDEMEN	N HEALTH CARE C	ENTED		1	:N, IN46506		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	ΓE	COMPLETION
TAG	<b>†</b>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		a.m. The head of the bed			degree angle and to include		
	was verified belo	ow 30 degrees. Also			ensuring that residents have slid down in the bed. To en		
	indicated that the	e head of the bed should			the deficient practice does no		
	be between 30 a	nd 45 degrees.			recur, the monitoring system		
		C			established is:A Performance		
	On 5/16/11 at 5:	45 p.m., Resident #27			Improvement indicator has b		
	1	ith the head of the bed at			established which evaluates		
					compliance with positioning		
	1 -	ne resident slid down in			G-tube residents in the bed a		
	bed in a position	lower than 30 degrees.			the head of bed elevated at a 45 degree angle. The Direct		
					Nursing or designee will com		
	An interview wa	s conducted with RN #8			indicator weekly for the first	picto	
	on 5/16/11 at 5:4	15 p.m., indicated that he			month, monthly for the first		
	checks Resident	#27 hourly but the staff			quarter and quarterly thereaf	ter	
		rent the residents from			with results forwarded to the		
	sliding down in				facility performance improve		
	Shamg down in	ocu.			committee for further evaluat		
	2 Danisland #20	's record was reviewed on			or resolution. POC Date: 6/2	3/11	
		a.m. Resident #28's					
	1 -	le, but were not limited to,					
	severe brain inju	ry, seizures, and					
	dysphagia.						
	On 5/16/11 at 6:	34 a.m., Resident #28					
		ith the head of the bed					
		rees while his continuous					
	1						
	1	s running. ADON					
	1 -	ition after entering the					
	room with this s	urveyor.					
	An interview wa	s conducted with the					
	ADON (Assistar	nt Director of Nursing) on					
	1	a.m. The head of the bed					
		ow 30 degrees. Also					
	1	e head of the bed should					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			I	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155474	B. WIN			05/24/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				OODIES LANE		
	NHEALTH CARE C	ENTER		BREME	EN, IN46506		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	be between 30 ar	nd 45 degrees.					
	3. Resident # 10'	s record was reviewed on					
	5/16/11 at 10:00	a.m. The Resident's					
	record indicated	diagnoses of, but not					
	limited to; stroke	e, gastric tube, diabetes,					
	dysphagia and ap	, •					
	, , , , , , , , , , , , , , , , , , ,						
	The Resident's re	ecord indicated she					
		Seedings by way of a					
	• • · · ·	ubic centimeter) and hour					
	*	e Resident's record					
	_	ation alert" on the					
	physician's order	sheet.					
	During a taum of	the facility on 5/16/11 at					
	"	the facility on 5/16/11 at					
	· ·	ent # 10 was observed in					
		body flat. The resident's					
	bed was raised, b	out the resident had slid					
	down in the bed	placing her body in a flat					
	position. The res	ident's feeding pump was					
	observed hooked	up to the resident's					
		ibe with the pump					
	~ ~ ~	g at 45 cc's (cubic					
	centimeters) an h	•					
	Commissions) and it	· · · · · · · · · · · · · · · · · · ·					
	During an intervi	iew with the ADON at					
	_	licated the resident					
	· ·						
		n placed higher in the					
	bed.						
		10/1/11 1 1 1					
	_	d 2/1/11 and updated on					
	4/19/11, indicate	d " Problem;Feeding					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU A. BUII		INSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155474	B. WING			05/24/2	05/24/2011	
	PROVIDER OR SUPPLIER		•	316 WC	ADDRESS, CITY, STATE, ZIP CODE DODIES LANE EN, IN46506			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE	
	bed) elevated 30 The plan of care ensure the Reside 30 degrees at all Review of the factoric procedure titled Enteral Feedings.	ch; Keep HOB (head of degrees at all times" lacked an intervention to ent's body is elevated at times.  cility's policy and 'Physician's orders for '," dated 10/31/10, levation of head of bed						
F0323 SS=G	environment remainst hazards as is possoreceives adequated devices to prevent Based on observative record review, the provide the necessory prevent a fall which irreparable fracture for 1 of 5 resident the sample of 19, supervision to prealtercations (Residual of 1 residents in	ation, interview, and e facility failed to ssary supervision to	F0	323	F-323  It is the practice of this facility ensure the highest quality of is afforded our residents.  Consistent with this practice, following has been done: The corrective action taken for the residents found to have been affected by the deficient practive was:Resident #40 fell in direct observation of staff however were unable to get to her in the surface of the	the e e tice ct they ime	06/23/2011	
		the supplemental sample or incidents. The facility			to prevent the fall. Preventat measures were in place at th	tive		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED	
		155474	B. WIN			05/24/2	011	
		I	D. 11111		ADDRESS, CITY, STATE, ZIP CODE	l .		
NAME OF	PROVIDER OR SUPPLIEF	8			OODIES LANE			
BREME	N HEALTH CARE C	FNTFR		1	:N, IN46506			
			_	<u> </u>			(7/5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE	
1710	+	ovide a hazard free		1710	time of the fall, and resident	had	DITTE	
		ated to unsecured steak			never disengaged the alarm			
					to fall. Resident #58 was			
		cured barrels containing			immediately separated from			
		l soiled incontinence			other resident at the time of t			
		rd had the potential to			altercation. Resident #68 wa			
	affect 10 of 79 re	esidents observed			immediately separated from unidentified male	trie		
	wandering on the	e North and South units			resident. Resident #45 was			
	and 15 of 15 resi	idents residing on the			immediately separated from	the		
	dementia unit.				other resident, assessed by			
					licensed nurse, physician no			
	Findings include	•			and orders received. Linen			
	i mamgs merade	•			barrels were secured in a ma			
	1 Desident #40	's clinical record was			in which residents can not accontents of the barrel and the			
					steak knives have been remo	-		
		6/11 at 2:35 P.M. and			from the rehabilitation room.			
	_	ses of, but not limited to:			corrective action taken for the			
	history of sacral	pelvic fracture,			residents having the potentia	al to		
	osteoporosis, ma	cular degeneration, senile			be affected by the same defi			
	dementia, and os	steoarthritis of the hips.			practice is:All areas of the ce			
					were reviewed to ensure no			
	During initial to	ur of the locked dementia			potential hazards were prese Additional staffing has been	ent.		
	_	nt 7:00 A.M., while			allocated to the dementia uni	it		
		LPN # 2, she indicated			during both day and evening			
		d sustained an irreparable			shifts to enhance supervision			
		•			residents. No other residents	-		
		ip from a recent fall on			were found to be affected by			
	the unit. Residen				these practices. The measu			
	1 -	idicated she was having			put into place and a systemic change made to ensure the	2		
	pain at the time.				deficient practice does not re	cur		
					is: Facility staff was educated			
	A "Resident Eve	nt Report Worksheet,"			ensuring that potential hazar			
	dated 5/3/11, ind	licated, "Event Nature:			are identified and safety prac			
		eant injuryEvent			are maintained. Additional s	taff		
		Fracture R (right)			have been allocated to the			
		Res (Resident) sitting in			dementia unit and have beer	1		
	1 ^ ^	, ,			educated on vigilance in supervision. To ensure the			
	lounge area on a	lz (Alzheimer) unit"			supervision. To ensure the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	(X2) MULTIP  A. BUILDING  B. WING		00	(X3) DATE COMPI 05/24/2	ETED
NAME OF PROVIDER OR SUPPL BREMEN HEALTH CARE		31	6 WOO	DDRESS, CITY, STATE, ZIP CODE DDIES LANE I, IN46506	•	
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PERCEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
The report indunsupervised in the dementia to Medication Aires, and nurse disengaged per to amb (ambut tried to get to before he could before he could before he could be fore to the sm staff on duty, it time of the fall buring observed on 5/16/11 at 8 station was observed with walker to (bathroom)5 sitting in Dayr Mobility Mon Dayroom got lost bal (balant R side"	icated Resident #40 was left in the central living area of init. "QMA (Qualified de) in a room with another in office on phone. Res. rsonal alarm and stood up ate). Nurse saw this and res., but she fell on R side d reach her."  ted in an interview on in P.M., Resident #40 fell all sofa. "There were two but they were busy at the in."  ation of the dementia unit is:00 A.M., the nurse's served to have a windowed ig the nurse from Resident is of the fall.  rse's Notes indicated the in P.MUp with assist of one			deficient practice does not rethe monitoring system established is: A Performance Improvement indicator has be established which evaluates compliance with safety monand supervision of residents assist in reducing the likelih resident events. The Direct Nursing or designee will conindicator weekly for the first month, monthly for the first quarter and quarterly therea with results forwarded to the facility performance improve committee for further evaluation or resolution. POC Date: 6/2	ce peen pitoring to pood of por of piplete  fiter pement pement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	(X3) DATH COMF 05/24/	PLETED
NAME OF PROVIDER OR SUPP BREMEN HEALTH CARI		316 WC	ADDRESS, CITY, STATE, ZIP O DODIES LANE EN, IN46506	CODE	
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PERCEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
1:55 A.MRe the floor with up with pants History5/23 -Resident in of from chair, le has been unst at 7:45 P.M front of chair to fall: wheel -Found sitting (dining room  A Care Plan, "Problem: At fallsnon-co secondary to Will be free f Approach:	mpliant with safety measures Dementia diagnosis/ Goal: rom falls with injury. assist with ambulation and bility monitor on while up				
incidents of a indicated, Da 7/3/10 at 12:3 slapped on th another reside on 1 on 1 sup however, the	the Resident to Resident buse, dated 7/9/10, te of Alleged incident - 0 P.M., Resident # 58 was e right side of her face by ent who was supposed to be ervision at the time, nurse providing 1 on 1 was one at the time of the				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  00	lì '	e survey pleted /2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CO ODIES LANE N, IN46506	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	3. Review of the incidents of abus indicated, Date of 8/7/10, untimed, down the south hurses station who 68 right leg being resident with his with his left hand.  4. Review of the incidents of abus indicated, Date of 12/20/10, untime a fall and bruise nurse on the unit when she heard hout of here". As room, she heard pushing me, you fall." When the she saw Residen room with a male her.  A facility policy 10/31/09, indicated "Verbalphysicates identare striprohibitedProlimeters.	Resident to Resident le, dated 8/8/10, of Alleged incident - RN # 38 was walking hallway towards the hen she saw Resident # g held down by another right hand as he hit her d. Resident to Resident le, dated 10/23/10, of Alleged incident - led, Resident # 45 suffered to the right forearm. The was in the lounge area Resident # 45 yell, "Get she started towards the the Resident say, "Stop Tre going to make me hurse entered the room, t # 45 on the floor of her the resident standing over  titled "Abuse", revised led, iland neglect of the ctly hibitions on abuse apply tentify residents most at and abuse, may					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	00	(X3) DATE COMP	ESURVEY LETED
		155474	A. BUILDING B. WING		05/24/	2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COI	DE	
				OODIES LANE		
	I HEALTH CARE C			EN, IN46506		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE API DEFICIENCY)	PROPRIATE	DATE
	dementiapsych	osocial, interactive,				
	and/or behavioral dysfunction"					
	5. During an env	ironmental tour of the				
	facility on 5/20/1					
	accompanied by	the Maintenance Director				
	# 41 and the Hou	isekeeper # 42, an				
		made of the Occupational				
		oor open. In the room an				
		made of 2 serrated steak				
	knives in a baske					
	•	servation was made of 10 ing unsupervised. There				
		member present in the				
	· · · · · · · · · · · · · · · · · · ·	erapy room. Residents				
	•	pational Therapy room to				
	visit the Therapy	Department on a daily				
	basis.					
	In the unlocked A	Alzheimer's unit used by the residents, an				
		made of two large 50				
		s. The containers were				
	_	for trash the other was				
	•	The large containers had				
	a plastic lid that	could easily be lifted off.				
		lents freely use this				
	bathroom, the ba					
	observed to be le	ft open.				
	During on intervi	iew with CNA # 28 on				
	-	.m. regarding the two				
	5,20,11 at 2.30 p	regarding the two				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155474	A. BUILDING	00 COMPLETED 05/24/2011	
		100474	B. WING		05/24/2011
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
BREMEN	I HEALTH CARE CE	ENTER		EN, IN46506	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG		accessible to residents,	IAG		DATE
	_	ildn't want my parents			
		could get into them and			
	they are contamin	_			
	they are containing	nated.			
	3.1-45(a)(1)				
	3.1-45(a)(1) 3.1-45(a)(2)				
	3.1 + 3(a)(2)				
F0325		nt's comprehensive			
SS=G	assessment, the ta	acility must ensure that a			
		ptable parameters of			
	nutritional status,	such as body weight and			
	•	ess the resident's clinical			
	possible; and	rates that this is not			
	•	rapeutic diet when there is			
	a nutritional proble				
		ations, interviews and	F0325	F-325	06/23/2011
	· · · · · · · · · · · · · · · · · · ·	e facility failed to ensure		It is the practice of this facilit	v to
		ined a normal weight		ensure the highest quality of	
		ent losing a significant		is afforded our residents.	
	•	t in one month (28.6		Consistent with this practice	
		not putting an immediate		following has been done: The corrective action taken for the	
	-	ace to aid in nutrition for		residents found to have been	
		eviewed for weight loss		affected by the deficient prac	l l
	in a sample of 19	(Resident # 54)		was:The dietician, physician POA were informed of the	, and
	Pludius 1 1 1			resident #54's weight loss or	n
	Findings include	•		5/19/2011. New orders were	l l
	Dagidant # 541	ecord was reviewed on		received to increase house	
		ecord was reviewed on .m. The Resident's record		supplement. Resident #54's weight has increased from 1	• • • • • • • • • • • • • • • • • • •
				lbs. to 130.1 lbs. After discu	l l
	_	ses of, but not limited to;		with family about resident #5	l l
	cerebrai vascular	accident with right		current condition, the decision	on

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	L DITT	A. BUILDING 00			COMPLETED	
		155474			-	05/24/20	011	
			B. WIN		ADDRESS OF STATE OF SORE			
NAME OF	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP CODE			
				1	OODIES LANE			
BREME	N HEALTH CARE C	ENTER		BREME	EN, IN46506			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	hemiplegia, dem	entia, and osteoporosis.			was made for Hospice to eva			
					resident #54. The corrective			
	A nhysician's or	der, dated 1/27/10,			action taken for those reside			
	1	d diet with nectar thick			having the potential to be aff			
					by the same deficient practic			
	1	cian's order, dated 2/2/11,			is:Residents identified as ha	· ·		
	1	se supplement 2.0 calorie			significant weight loss for the month of June received	·		
	give 60 cc (cubic	c centimeter) by mouth			necessary follow-up with			
	daily. DX (diagr	nosis) Nutritional			physician and dietician. An			
	supplement.	•			immediate intervention has b	<sub>oeen</sub>		
	зарргениен.				put into place and reflected of			
	The Desident C	454 - 4 HT., 45 - 141			resident's plan of care. <i>The</i>			
		orm titled "Individual			measures put into place and			
	Resident Weight	History" indicated the			systemic change made to er	nsure		
	weights on the fo	ollowing dates:			the deficient practice does n	ot		
					recur is: Residents at risk for	-		
	1/9/11- weight w	vas 141			weight loss will be identified			
	2/9/11- weight w				through the weekly resident			
					risk meeting. Ongoing evalu			
	3/6/11- weight w				and weight monitoring will or			
	4/11- weight was				to ensure timely and approprintervention. Licensed nursing			
	5/11- weight was	s 128.5 the reweight was			staff re-inserviced regarding	<sup>ig</sup>		
	126.9				physician notification related	to		
	Total weight loss	s from April to May was			change of condition. The fac			
	28.6 pounds.	1			dietician was in-serviced by			
	20.0 pounds.				regional dietician related to			
	N	. 1 4/17/11 4 . 5/15/0011			updating care plans for weig	ht		
	1	ted 4/17/11 to 5/15/2011,			loss. To ensure the deficient			
		tation indicating the			practice does not recur, the			
	physician had be	een notified of the			monitoring system establishe			
	significant weigh	nt loss for May so further			is:A Performance Improveme			
	1 -	ention and orders could be			indicator has been establishe			
	obtained.				which evaluates compliance			
	Journey.				care plans related to weight The Director of Nursing or	1055.		
		1 0 1.1			designee will complete indicate	<sub>ator</sub>		
	1	lan of care, dated			weekly for the first month,	101		
	3/15/10, indicate	ed "Problem: Significant			monthly for the first quarter a	and		
	weight loss (Mar	rch 2010) Leaves 25% or			quarterly thereafter with resu			
	1 -	ost meals, at risk for			forwarded to the facility			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL		
		155474	A. BUI B. WIN	LDING IG		05/24/2	
NAME OF	PROVIDER OR SUPPLIE	<b>  </b> 			ADDRESS, CITY, STATE, ZIP CODE		
				1	OODIES LANE		
	N HEALTH CARE C				N, IN46506		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES  ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	choking Dx (diagnosis) Hiatal Hernia,				performance improvement		
	Dx: Dysphagia	.Approach:Notify RD		committee for further evaluation			
	(Registered dieti	tian) and MD (Medical			or resolution. POC Date: 6/2	3/11	
	Doctor) of signi	ficant weight changes"					
	The Resident's r	ecord lacked					
		ndicating the Dietitian					
	1	d of the significant weight					
	loss so an interv	ention could have been					
	put in place imm	nediately.					
	The resident's re	cord was reviewed on					
	5/18/11 at 8:50 a	ı.m., with a concern					
	shared for weigh	it loss. On 5/19/11, the					
	resident's record	indicated a note from the					
	Dietitian was ad	ded to the resident's					
	record. The Die	titian's note					
	1	ne recent significant					
	1 -	to increase the House					
	1 ^ ^	d add weekly weights to					
	monitor"						
	The resident's fo	rm titled "Individual					
		ntake Record" dated					
	1	icated the Resident was					
	1	at 25% of her meals for					
		nch and dinner her intake					
	1	f her meals. The March					
	1	for the a.m. and p.m.					
		the Resident consumed					
	nearly all of the	food and fluids offered.					
	The Resident's f	orm titled "Individual					
		ntake Record" dated April					

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l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	li i	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		316 WC	ADDRESS, CITY, STATE, ZIP ( DODIES LANE EN, IN46506	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	the resident had also the alternate lacked document	rom April 9th to the 15th, refused her supper and . The resident's record ration to indicate the hysician had been				
	# 54 refused all t April meal intake entire month of A than 25% with re meals and alternal lack documentate physician or the	e form indicated Resident hree meals that day. The e form indicated for the April, her intake was less efusal of many of the ates. The nurses notes ion to indicate the dietitian had been er interventions could				
	Resident # 54 incof her meals and through the 9th, dinner meals and Resident's meal in May was less that May 2011 lack do the dietitian or the notified of the Reseveral days in a					
		ecord indicated Resident nsive assistance with				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		A. BUI	LDING	NSTRUCTION 00	COM	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DODIES LANE N, IN46506		
	SUMMARY S (EACH DEFICIEN REGULATORY OR On 5/17/11 at 1:0 was observed in resident was obs pureed lunch. Ob staff attempting to her meal, she ref alternative was observed Staff was observed when the resident During an intervent of the staff	ENTER  TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  00 p.m., Resident # 54 the dining room. The erved refusing to eat her oservation was made of to assist the Resident with used to eat. No bserved being offered. ed to give up quickly t refused to eat.  iew with CNA # 5 on .m. regarding resident # te indicated it was to get her to eat.  iew with the Director of 11 at 5:00 p.m., t loss for Resident # 54, hould have been imely.	B. WIN	STREET A	OODIES LANE	TION D BE	(X5) COMPLETION DATE
	Risk, Nutritional Significant Chan indicated "Sign or improvement a. Will not norm intervention by standard diseased interventions, is Impacts more that patient's health s	roblem and/or ge" dated 10/31/10, afficant Change, a decline in a patient's status that: ally resolve itself without taff or by implementing d-related clinical not "self-limiting", b. an one area of the tatus; and c. Requires review of the care plan					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155474		(X2) M A. BUII B. WIN	LDING G	NSTRUCTION  00	(X3) DATE: COMPL 05/24/2	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  316 WOODIES LANE BREMEN, IN46506				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0328 SS=G	proper treatment a special services: Injections; Parenteral and en Colostomy, ureter Tracheostomy car Tracheal suctionin Respiratory care; Foot care; and Prostheses. Based on observice and en compromised an resident with consecretions which violently coughing breath. This definition of 1 residents recisample of 19. (Findings include Resident #27's respectively.)  Findings include Resident #27's respectively.	ation, interview, and e facility failed to ssary suctioning to the airway of a medically d totally dependent bious amounts of resulted in the resident ng and struggling for ceient practice affected 1 reiving suctioning in a desident #27)	FO	328	F-328  It is the practice of this facility ensure the highest quality of is afforded our residents.  Consistent with this practice following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: Resident #27 is able to mobilize secretions independent and does not require frequent suctioning. His oxygen sature level was between 84% and during the suctioning proced on 5/16/11. Licensed nursing staff was in-serviced on tracheostomy care and suctification with the Staff Development. Coordinator and the Respiration Therapist. There were no negative outcomes to reside #27 related to tracheostomy. The corrective action taken.	tory  transport  trans	06/23/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155474	A. BUI	LDING	00	COMPL 05/24/2	
		155474	B. WIN			03/24/2	011
NAME OF	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
RDEMEN	N HEALTH CARE C	ENTED		1	OODIES LANE EN, IN46506		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	DATE
1710	tracheostomy on 10/06/2003.		+	ing	those residents having the		DATE
	l deficosionly on	10/00/2003.			potential to be affected by th	е	
	0: 5/16/11 -46.	11 DN 46 DN 47			same deficient practice is:Th		
		11 p.m., RN #6, RN #7,			facility has no other residents		
	· ·	ON were observed			having the potential to be aff	ected	
		ositioning Resident #27.			as Resident #27 is the only resident receiving tracheosto	mv	
		s observed with a			care. The measures put into	-	
		l oxygen at 4 liters			place and a systemic change	,	
	_	h tracheotomy mask.			made to ensure the deficient		
		ompleted all of the staff			practice does not recur is: Licensed nursing staff has be	oon	
	except the ADO				in-serviced related to	5611	
	_	nen exiting the room a			tracheostomy care including		
	_	mucus was noted inside			competency testing with retu	rn	
		nula of the tracheotomy.			demonstration. The Staff	_	
		asked to lift the sheet to			Development Coordinator ha and will continue to observe		
		n of the nail beds.		staff providing tracheostomy care			
		ail beds were blue/gray in		and suctioning. To ensure the			
		gers were mostly blue in			deficient practice does not re	ecur,	
		#27 was also noted to be			the monitoring system established is:A Performance	_	
		iolent cough. The inner			Improvement indicator has b		
	lumen of the oxy	gen tubing was noted to			established which evaluates		
		ostructed with mucus.			compliance with trach care.		
	At 6:42 p.m., RN	N #8 was requested to			Director of Nursing or design		
		m with a biox (to test			will complete indicator weekl the first month, monthly for the	-	
	blood oxygen le	vels), Resident #27's biox			first quarter and quarterly	.0	
	was 84%.				thereafter with results forwar	ded	
	At 6:49 p.m., RN	N #8 brought suction			to the facility performance		
	equipment to roo	om. Resident #27			improvement committee for further evaluation or		
	observed coughi				resolution. POC Date: 6/23/1	1	
		erile technique was					
	-	8 when sterile gloves					
		with proper technique.					
	At 6:54 p.m., Re	esident #27's biox is 87%,					
oral mucus secretions visualized, Resident							
	#27 was observe	ed gagging.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155474	A. BUI		00	05/24/2	
		100474	B. WIN			03/24/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BREMEN	N HEALTH CARE CE	ENTER		1	EN, IN46506		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	πE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 .	#8 began suctioning but					
		nique when the tip of the					
	1	uched the resident's					
	· ·	left to retrieve more					
	1 ^ ^	biox was 86%, mucus					
	1	rgling from resident's					
	mouth.						
	_	e ADON was unsure of					
		to retrieve, returns for					
	assistance from F						
		ction equipment was					
	1 ~	ent #27's room. The					
	l '	ghing violently, gagging,					
	_	ard in bed. Biox was					
		icated that he does not					
	1	nd he had only been on					
		ouple of weeks. RN #8					
		mpleting tracheotomy					
	_	sident #27. RN #8 failed					
	1 ^	catheter into sterile					
		to check for functioning					
	1 ^ ^	ibricate the suction					
		eginning the procedure.					
		oned while inserting the					
		tracheotomy. Suctioning					
	I -	10 seconds and not					
		#8 did not wait for thirty					
		suctioning episodes.					
	_	ox up to 89%, DON now					
		n. Requested different					
	biox to compare						
	_	fferent biox brought to					
	· ·	27's biox was then 93%.					
	Resident was the	n cleaned and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	li i	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER		316 WC	ADDRESS, CITY, STATE, ZIP C DODIES LANE EN, IN46506	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Plan Report," dan "ProblemAt a distressGoalV Respiratory Distress ordered, monitand symptoms) of labored breathing oxygen), measur ordered, Lung as prn (as needed) Physician and Faneeded"  The "Treatment I stated, "Oxyge mask to maintain or greater"  The "Medication stated, "May so needed"  The "Medication stated, "May so needed) for increated"  The "Medication stated, "May so needed) for increated, "O2 (ox saturation greater	Comprehensive Care ted 4/5/11, indicated that, risk for respiratory Will have no or minimal ressApproachOxygen tor & report s/sx (signs of shortness of breath, g and/or cyanosis (lack of e oxygen saturation as sessment as ordered and suction as neededKeep amily informed as  Record" for May of 2011 in to trach (tracheotomy) in oxygen saturation 90%  Record" dated May 2011 inction oral cavity as  Record" dated May 2011 inction trach prn (as ease secretions"  Record" dated May 2011 inction trach prn (as ease secretions"  Record" dated May 2011 inction trach prn (as ease secretions"				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED
		155474	B. WIN			05/24/2011
			_		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIER			316 WC	OODIES LANE	
	N HEALTH CARE CI				EN, IN46506	
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
		ion on 5/16/11 from 6:11				
	1 -	.m. RN #8 indicated a				
	1 1	sment was not completed				
	1 ^	ng or immediately after				
	1	staff to determine lung				
	function/sounds.	RN #8 also indicated				
	the physician sho	ould have been notified.				
	The policy titled	, "Comprehensive				
	Assessment" date	ed 3/05/08 was reviewed				
	on 5/24/11 at 2:3	0 p.m. stated,				
		ssessment Data- Resident				
	data collected so					
	1	on of the resident's				
	I -	ntal condition or abilities				
	1 ^ -	ed by the appropriate				
	I -					
	1 ^	is documented on				
	1	s. Data may include, but				
	1	Vital signsResident				
	changesObserv					
	1	e oximetryResponse to				
	1	tiveness of treatment				
	Oral status"					
	1 .	tled, "Endotracheal Care				
	1	ated 10/31/07 was				
	reviewed on 5/24	4/11 at 4:15 p.m. stated,				
	"Rationale: Su	ctioning of the resident's				
	airway removes	increased secretions and				
	prevents airway	obstruction and				
		edure4. wash hands. 5.				
	_	heter package. 6. Put on				
	1 -	le gloves and remove				
	1	7. With the un-sterile				

	NOT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE (X6) MUL				(X3) DATE SURVEY  COMPLETED  05/24/2011			
	PROVIDER OR SUPPLIER		B. WING O3/24/2011  STREET ADDRESS, CITY, STATE, ZIP CODE  316 WOODIES LANE  BREMEN, IN46506					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIAT DEFICIENCY)	TE.	(X5) COMPLETION DATE	
F0332	hand, disconnect aerosol or oxyger suction catheter of tube until resistant the catheter sligh while removing to Re-oxygenate the steps 8-10 until a removed or up to of the procedure. Outcome12. Dhas been success following: a. Rer Improvement of clearing of cough place resident bacoxygenDocume Guidelines2a status3a. Data notification4. No member/responsions	the resident from the  1. 8. Gently pass the down the endotracheal nce is met then withdraw tly. 9. Apply suction he catheter. 10. e resident11. Repeat ll secretions have been the resident's toleranceAssessment of etermine if suctioning ful by one or more of the moval of secretions; b. breath soundse. a13. When completed, ck on the aerosol or entation of a. Respiratory e and time of physician lotification of family ble party"						
SS=D	Based on observation record review, that a medication error of 12 residents medications. The	ates of five percent or  ation, interview, and e facility failed to ensure or rate of less than 5% for observed receiving ree errors in medication ere observed during 40	FO:	332	F-332  It is the practice of this facility ensure the highest quality of is afforded our residents.  Consistent with this practice, following has been done: The corrective action taken for the residents found to have been	care the	06/23/2011	

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155474	B. WIN			05/24/2011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER				OODIES LANE	
BREMEN	N HEALTH CARE CE	ENTER		1	EN, IN46506	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
	^ ^	error. This resulted in a			affected by the deficient prac	
	medication error	rate of 7.5%.			was:LPN #17 received imme re-education related to sliding	
					scale insulin administration for	~ I
	Residents: #72,	# 80, # 95			resident #80. Resident #95"	
	Findings include:  1. The clinical record for Resident # 80				physician was notified regard	
					the medication variance rela	
					the Folic Acid. No new order	rs
					were received and no negati	
					outcome related to this varia	
was reviewed on 5/16/11 at 10:45 A.M.  A Physician Order, dated 2/5/11,					Pharmacy was immediately	
					notified regarding the dosage discrepancy of the Ferrous	;
					Gluconate for resident #72.	
	indicated, "Glucometers twice dailySliding Scale. If blood sugar				Resident #72's physician wa	s I I
					made aware and the medica	
	60-150=0 units,	•			order was clarified. Residen	t #72
		, 251-300=12 units,			had no negative outcome rel	
		s, 351-400=16 units, Call			to the Ferrous Gluconate dos	
		ar less than 60 or greater			discrepancy. The correcti action taken for those reside	
		ar less than 60 or greater			having the potential to be aff	
	than 350"				by the same deficient practic	
					is:All other facility residents h	
	_	ication pass on 5/16/11 at			the potential to be affected b	y this
	4:20 P.M., LPN	# 17 performed an Accu			practice. Pharmacy and Nur	sing
	Check which was	s 326. She drew up			Administration checked all	
	Humalog insulin	16 units. She entered			medication carts and medica	
	Resident # 80's re	oom in preparation to			administration records to ensethat medication orders match	· ··· · ·
	give the insulin a	and was stopped just prior			medications available. The	'
	to the injection b				facility created a blood	
		emg givem			sugar/insulin binder for easy	
	I DN # 17 indicat	ted the correct sliding			monitoring, correct	
		•			administration, and	
	scale dose was 1	4 units.			documentation of glucomete	
					results, routine insulin, and s scale coverage. The measu	
		ecord for Resident # 95			put into place and a systemic	
	was reviewed on	5/20/11 at 2:15 P.M.			change made to ensure the	´
					deficient practice does not re	ecur
	A Physician Orde	er, dated 5/16/11,			is: Licensed nursing staff has	
		· · · · · · · · · · · · · · · · · · ·				

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155474	B. WIN	IG		05/24/2	011
NAME OF	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	I KOVIDEK OK SOI I EIEI			316 WC	OODIES LANE		
	N HEALTH CARE C				EN, IN46506		
(X4) ID	1	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG	<del> </del>	LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	· ·	ic Acid (supplement) 0.4			been re-serviced on double checking the dosage when w	ritina.	
	mg, 2 po (orally)	) daily"			the medication orders, the five	•	
					rights of medication		
	During second n	nedication on 5/18/11 at			administration and following	the	
	9:55 A.M., LPN	# 19 gave Folic Acid 0.4			sliding insulin orders regardi		
	mg - 1 pill.				documentation of the amoun		
					insulin given. Licensed staff been re-inserviced on the ne		
	LPN # 19 indica	ted that she should have			binders put into place for	VV	
		Acid pills instead of one.			monitoring and documenting		
	gryon two rong	pino movem or one.			blood sugars/insulins. <i>To ei</i>		
	3 The clinical r	ecord for Resident # 72			the deficient practice does n		
	was reviewed on 5/18/11 at 2:00 P.M.				recur, the monitoring system		
					established is:A Performance		
		1 . 1 11/0 1/10			Improvement indicator has b established which evaluates	een	
	1 -	er, dated 11/24/10,			compliance with checking		
	1	rous Gluconate (iron) 325			medication dosage against the	ne	
	mg"				physician orders and followir		
					sliding scale insulins and		
	During first med	lication pass on 5/17/11 at			documenting what was giver	۱.	
	9:00 A.M., LPN	# 18 gave Ferrous			The Director of Nursing or designee will complete indicate	etor	
	Gluconate 324 n	ng.			weekly for the first month,	atoi	
					monthly for the first quarter a	ınd	
	Interview on 5/1	8/11 at 4:40 P.M., the			quarterly thereafter with resu	lts	
	1	of Nursing) indicated the			forwarded to the facility		
	`	nsure why they sent			performance improvement committee for further evaluate	ion	
	1 *	ate 324 mg (milligrams)			or resolution. POC Date: 6/2		
		dered 325 mg dose.			0/ 1000/dilo/// 1 00 Bdio: 0/2	O/ 11	
	Instead of the of	dered 525 mg dese.					
	A facility policy	titled "Medication					
	1	revised 10/31/10,					
	1	epare the medication using					
	•						
	the five right of						
		.Right medication name					
	1	ead the medication					
	order(s), and aga	nin compare with the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	NING	00	COMPL	ETED
		155474	B. WING		<del></del>	05/24/2	011
NAME OF P	PROVIDER OR SUPPLIER		p. wiito	STREET A	DDRESS, CITY, STATE, ZIP CODE		
BREMEN	I HEALTH CARE CE	ENTER		BREME	N, IN46506		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	3.1-25(b)(9) 3.1-48(c)(1)	I(s)"					
F0353 SS=E	The facility must he to provide nursing attain or maintain aphysical, mental, a of each resident, a assessments and. The facility must personnel on a 24 nursing care to all with resident care. Except when waive this section, licens nursing personnel. Except when waive this section, the fallicensed nurse to seach tour of duty. Based on observative record review, the provide sufficient with a fracture (Finumerous resident (Resident #45, #5).	ed under paragraph (c) of ed nurses and other	F03	53	F-353  It is the practice of this facility ensure the highest quality of is afforded our residents.  Consistent with this practice, following has been done: The corrective action taken for the	the	06/23/2011
	residents in the s	upplemental sample of ack of supervision.			residents found to have been affected by the deficient prac was:The facility can not asce that additional staff would hav prevented resident #40's fall	<i>tice</i> rtain ve	

TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  THE STAFF WERE IN DIFFERENCED TO THE APPROPRIATE DEFICIENCY)  The staff were in direct observation of the resident at the time of the fall. Resident's #46, #47, #49 and #95 had no affects from the observations made during the course of the survey. Resident #38 and #45 have not had additional incidents since the reported incidents. The corrective action taken for those		ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:  155474			LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/24/2	ETED
PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  1. During initial tour of the locked dementia unit on 5/16/11 at 7:00 A.M., while accompanied by LPN # 2, she indicated 12 of the 15 residents residing on the unit were incontinent and needed assistance for toileting. She further indicated Resident #40 had sustained an				B. WIN	STREET A	OODIES LANE		
1. During initial tour of the locked dementia unit on 5/16/11 at 7:00 A.M., while accompanied by LPN # 2, she indicated 12 of the 15 residents residing on the unit were incontinent and needed assistance for toileting. She further indicated Resident #40 had sustained an observation of the resident at the time of the fall. Resident's #46, #47, #49 and #95 had no affects from the observations made during the course of the survey. Resident #38 and #45 have not had additional incidents since the reported incidents. The corrective action taken for those	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ATE	COMPLETION
irreparable fractured right hip from a recent fall on the unit.  A "Resident Event Report Worksheet," dated 5/3/11, indicated, "Event Nature: Fall with significant injuryEvent Adverse effect: Fracture R (right) hipPain R hipRes (Resident) sitting in lounge area on alz (Alzheimer) unit"  The report indicated Resident #40 was left unsupervised in the central living area of the dementia unit. "QMA (Qualified Medication Aide) in a room with another res. and nurse in office on phone. Res. disengaged personal alarm and stood up to amb (ambulate). Nurse saw this and tried to get to res., but she fell on R side before he could reach her."  LPN #3 indicated in an interview on 5/17/11 at 3:00 P.M., Resident #40 fell next to the small sofa. "There were two staff on duty, but they were busy at the time of the fall."  residents having the potential to be affected by the same deficient practice is:No other residents were affected by the deficient practice is:No other residents were affected by the deficient practice, however additional staff has been allocated to the Reflections/Dementia unit to assist with supervision to include monitoring of resident behavior, responding to alarms and ensuring residents bear ensuring residents are prepared for meal times. The measures put into place and a systemic change made to ensure the deficient practice does not recur is: The executive director and director of nursing have been in-serviced related to ensuring that appropriate staffing levels and supervision is present to meet the needs of the residents. To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement indicator has been established which evaluates compliance with the placement and presence of additional staff resources. The Executive Director or designee will complete monithly for the first quarter and quarterly thereafter		1. During initial dementia unit on while accompaniindicated 12 of the on the unit were assistance for too indicated Reside irreparable fracturecent fall on the A "Resident Ever dated 5/3/11, ind Fall with signific Adverse effect: I hipPain R hip lounge area on all The report indicature unsupervised in the dementia unity Medication Aideres, and nurse in disengaged persot to amb (ambulate tried to get to reside before he could in the termination of the fall."	tour of the locked 5/16/11 at 7:00 A.M., ed by LPN # 2, she he 15 residents residing incontinent and needed leting. She further ht #40 had sustained an ared right hip from a unit.  Int Report Worksheet," icated, "Event Nature: ant injuryEvent Tracture R (right)  Res (Resident) sitting in z (Alzheimer) unit" ated Resident #40 was left the central living area of			the staff were in direct observation of the resident itime of the fall. Resident's #47, #49 and #95 had no affrom the observations made during the course of the sur Resident #38 and #45 have had additional incidents since reported incidents. The corrective action taken for the residents having the potentiable affected by the same despractice is: No other resident were affected by the deficie practice, however additional has been allocated to the Reflections/Dementia unit to assist with supervision to in monitoring of resident behaves responding to alarms and ensuring residents are prepfor meal times. The measur put into place and a system change made to ensure the deficient practice does not ris: The executive director and director of nursing have been in-serviced related to ensure the deficient practice of the resid to ensure the deficient practice does not recur, the monitorial system established is: A Performance Improvement indicator has been established is: A Performance Improvement indicator has been established is: Executive Director or design will complete monthly for the sign	at the #46, fects evey. not ce the cose ficient at the fects of the cose ficient at the cose ficient at the cose fice fice fice fice fice fice fice fic	

	IT OF DEFICIENCIES OF CORRECTION	TION IDENTIFICATION NUMBER:  A. BUILDING  OD  OD  OD  OD  OD  OD  OD  OD  OD  O		LETED			
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DODRESS, CITY, STATE, ZIP CODE DODIES LANE N, IN46506		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFRENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION
TAG	on 5/16/11 at 8:0 station was obser	O A.M., the nurse's rved to have a windowed he nurse from Resident f the fall.		TAG	with results forwarded to facility performance improcommittee for further eva or resolution. POC Date:	vement uation	DATE
	Service/Director Resident #47's resident #47's resident #47's resident #95 was observed in the central living unit. Resident #9 mobility alarm so unit failed to hear because they were resident's room presponded for a full Social Service/Dobserved assisting to the dining room (Resident #47) do she made the state observed attempt the East door. The and CNA #27 resident #43 away At 5:54 P.M. (5/	e and CNA #27 was dent #49's room inence care. Resident d sitting on a small sofa ng area of the dementia 5 stood up and his ounded. Both staff on the r his alarm sounding re each in another rroviding care. No one sident #95. His alarm I five minutes before the irector appeared. She was g Resident #47 ambulate m. She stated, "Is that I can't help him until I get own." Immediately after rement, Resident #43 was sing to exit the unit via the door alarm sounded sponded and re-directed any from the door.  18/11), the Social					
		asked QMA #31, who e unit to pass dinner					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE COMP 05/24/2	LETED
	PROVIDER OR SUPPLIER		B. WINC	STREET A	DODIES LANE N, IN46506	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	up for dinner. The Nurse #32, who help pass dinner would get Reside down for dinner. assisted to the different tablemate's with meals and were decreased and were decreased and were decreased and one CNA self-3:00 P.M. and the shift. The 11:00-one nurse or one dates when the CP.M7:00 A.M.) North unit is one that arise on the decreased and revised 4/"Rationale: Each has sufficient nursing and relational and psyceach residentCoDetermine the	dicated there is one nurse needuled for the 7:00 A.M. as 3:00 P.M11:00 P.M. 7:00 A.M. shift has either CNA scheduled. On P.M. is scheduled (11:00 and the nurse from the call for emergency needs dementia unit.  Titled "Sufficient Nursing 28/10, indicated, (Name) nursing center raing staff to provide ed services to attain or nest practicable, physical, thosocial well-being of the enter Quality of Care: level and mix of staff atted to address specific					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155474			ULTIPLE CON LDING G	nstruction 00	(X3) DATE S COMPL <b>05/24/2</b>	ETED
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE ODIES LANE N, IN46506		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	incidents of abusindicated, Date of 7/3/10 at 12:30 If slapped on the right another resident on 1 on 1 supervisions however, the number of the telephone incident.  3. Review of the incidents of abusindicated, Date of 8/7/10, untimed, down the south If nurses station with 68 right leg being resident with his with his left hand.  4. Review of the incidents of abusindicated, Date of 12/20/10, untimed a fall and bruise nurse on the unit when she heard out of here". As room, she heard pushing me, you fall." When the she saw Residen	of Alleged incident - O.M., Resident # 58 was ght side of her face by who was supposed to be ision at the time, see providing 1 on 1 was at the time of the  Resident to Resident see, dated 8/8/10, of Alleged incident - RN # 38 was walking nallway towards the men she saw Resident # g held down by another right hand as he hit her	F0	353	It is the practice of this facility ensure the highest quality of is afforded our residents. Consistent with this practice, following has been done: The corrective action taken for the residents found to have been affected by the deficient practice, that additional staff would haprevented resident #40's fall the staff were in direct observation of the resident's #47, #49 and #95 had no affer from the observations made during the course of the survented that additional incidents since reported incidents. The corrective action taken for the residents having the potential be affected by the same definitional has been allocated to the Reflections/Dementia unit to assist with supervision to incomonitoring of residents and ensuring residents are prepared for meal times. The measure put into place and a systemic change made to ensure the deficient practice does not resis: The executive director and director of nursing have been in-serviced related to ensuring that appropriate staffing level.	the strice rtain ve as at the strice the str	06/23/2011

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155474  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 05/24/2011					
	ROVIDER OR SUPPLIER			316 WO	DDRESS, CITY, STATE, ZIP CODE ODIES LANE N, IN46506	I	
				<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0363 SS=E	residents in accord recommended die and Nutrition Boar Council, National A prepared in advan Based on observa record review, the the required no-s	tary allowances of the Food d of the National Research Academy of Sciences; be ce; and be followed. ation, interview, and e facility failed to ensure alt beef base was	F0	363	and supervision is present to meet the needs of the reside To ensure the deficient pract does not recur, the monitorin system established is:A Performance Improvement indicator has been established which evaluates compliance the placement and presence additional staff resources. T Executive Director or designed will complete monthly for the quarter and quarterly thereaf with results forwarded to the facility performance improved committee for further evaluate or resolution. POC Date: 6/25	nts. ice ig  ed with of he ee first iter ment ion 3/11	06/23/2011
	deficient practice affect 5 of 6 resid puree diet. Findings include	pureed recipe. This had the potential to dents on a no-added salt  on of the facility kitchen			is afforded our residents. Consistent with this practice, following has been done: The corrective action taken for the residents found to have been affected by the deficient practices. Was:No residents were found be affected by this practice. Corrective action taken for the residents having the potential	ents.  practice, the practice the practice the practice practice practice to the practice to the practice to the practice to the practice the practice to the practice the pra	
	#33 was observed meat for the ever	0 P.M., Dietary Cook d preparing the puree ning meal. He placed 12 ed country fried beef			be affected by the same definence is: No other residents were affected by this practice. The measures put into place a systemic change made to	cient s e.	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	(X2) MUI  A. BUILE  B. WING	DING	00	(X3) DATE : COMPL 05/24/2	ETED
	PROVIDER OR SUPPLIER			316 WO	DDRESS, CITY, STATE, ZIP CODE ODIES LANE N, IN46506		
(X4) ID PREFIX TAG	summary s (EACH DEFICIEN REGULATORY OR  patties into the for called for sodium #33 indicated the in the facility had Dietary Manager purchase sodium returned with low Upon return and Manager indicate	cratement of deficiencies (CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  cood processor. The recipe in-free beef base. Cook the only beef base available d sodium in it. The in-free beef base, but in-free beef base. in interview, The Dietary	P	ID REFIX TAG	ensure the deficient practice not recur is: All facility recipe were reviewed to ensure tha appropriate ingredients are available to prepare foods according to recipe. Dietary cooks have been in-serviced adherence to menus and recording to recur, the monitoring system established is:A	does s t to cipes.	(X5) COMPLETION DATE
	supermarket. The contained 45 mil serving. The Die she understood t sodium-free beef processed beef a sodium. She furt	e low-sodium beef base ligrams of sodium per tary Manager indicated			indicator has been established which evaluates compliance all menus and recipes are be followed. The Nutritional Secure Director or designee will complicate weekly for the first month, monthly for the first quarter and quarterly thereal with results forwarded to the facility performance improve committee for further evaluation resolution. POC Date: 6/2	with eing rvice aplete fter ment cion	
	residents with sp by the Dietary Si indicated six resi	ary report, which listed secial diet needs, provided supervisor on 5/24/11, idents received puree those six were on a set.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIC	00	COMPL	ETED
		155474	A. BUII B. WIN			05/24/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t			OODIES LANE		
BREMEN	I HEALTH CARE CI	ENTER	BREMEN, IN46506				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF C			
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
F0371	The facility must -						
SS=F		rom sources approved or					
	local authorities; a	actory by Federal, State or					
		, distribute and serve food					
	under sanitary cor						
•	_	ation and interview, the	FO	371	E274	•	06/23/2011
		lity failed to ensure proper sanitation			F371		
	of the facility kitchen, two refrigerators on				It is the practice of this facilit	•	
	_	tchen, two refrigerators on and a microwave in the			ensure the highest quality of	care	
South Dining Room sanitary to promote 91 of 94 residents w					is afforded our residents.  Consistent with this practice	the	
		*			following has been done: Th		
		_			corrective action taken for th		
		is who eat in the facility.			residents found to have bee	n	
		ngs include			affected by the deficient prac	ctice	
	Findings include	:			was:The kitchen staff hand		
					washing sink has been clear		
	A. During obser	vation of the facility			The stainless steel plate war has also been cleaned. The		
	kitchen on 5/16/	11 at 6:30 A.M., while			cooked ham loaf and the		
	accompanied by	Dietary Cook #34, the			uncovered cookies were		
	following was ob	oserved:			discarded immediately. The		
	_	aff handwashing sink was			bacon was discarded		
		ld-up of a beige and red			immediately. The delivery m		
	dust.	ra up or a serge and rea			has been provided a hair res and made aware of necessa		
		el plate warmer was			adherence to this policy. Th		
		ky brown substance. 3. A			beautician has been re-inser		
		•			to not enter the kitchen with	out	
		was observed resting on			use of a hair restraint. Cook		
	-	aw hamburger in the			has been re-inserviced on pi		
	walk-in cooler.				glove use while in the kitche	n.	
	<del>-</del>	incovered cookies in the			The kitchen refrigerator was cleaned immediately and the	two	
	walk-in cooler.				cartons of tomato juice were		
	5. Bacon with an	expiration date of			discarded. All staff has been		
	5/09/11 in the wa	alk-in cooler.			in-serviced on not entering the		
	6. A food deliver	ry man entered the			kitchen without a hair restraint.		
		without a hair restraint. 7.			The can opener point was cleaned immediately. The fo	our	
		itician entered the main			cartons of buttermilk were	Jul	
					Santonio on Sattonniiii Word		l l

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155474	A. BUI	LDING	00	05/24/2	
		133474	B. WIN			03/24/2	011
NAME OF	PROVIDER OR SUPPLIE	3		1	DDRESS, CITY, STATE, ZIP CODE		
BREME	N HEALTH CARE C	FNTFR		1	OODIES LANE N, IN46506		
(X4) ID		STATEMENT OF DEFICIENCIES		ID			(V5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	area of the kitch	en without a hair restraint.			discarded immediately. The		
	8. Cook #34 mo	ved from task to task			dented can of Sauerkraut wa	ıs	
	touching several	different surfaces,			discarded immediately. The shelves in the dry food storage	70	
	1 -	dishes in the sink, items			area were cleaned immediate		
	1	ooler and storage room,			The food tray cart was clean	-	
		g gloves and washing			immediately. The knobs on t	the	
	hands prior to ha				steam table were cleaned	nlata	
	1 -	located in the kitchen			immediately. The lids to the warmer were cleaned	piate	
	1	ed inside with dried			immediately. The four stainle	ess	
	1	d particles. Two cartons of			steel cookie sheets were clea		
	1 -	pired 2/28/11 were inside			and dried immediately. The		
	the refrigerator. The outside was heavily				plates were cleaned immedia and the plate that was chippe		
		ld-up greasy hand prints			was discarded. The two juice		
	and dried food.	of grown process			pitchers and five sippy cups		
					cleaned immediately. The tw	vo	
	During observat	ion of the kitchen on			dish carts were cleaned immediately. The kitchen sta	off	
		A.M., the following was			has been in-serviced on the	a11	
	observed:	Thirti, the following was			proper technique to maintain	the	
		ered the kitchen without a			proper temperature regarding		
	hair restraint.	area the known without a			dish machine for the first bate dishes. The hands free hand		
		er point was laden with a			washing sink has been chang		
	build-up of dried	•			to a non hands free device.		
	1 ^	of buttermilk, dated			pots and pans were rewashe		
		se by 5/04/11 date, were			and a heater for the triple sin	k	
	in the walk-in co				has been ordered to help maintain proper temperature	s.	
		of Sauerkraut on storage			The refrigerator in the		
	shelf.	or succession on morago			Occupational Therapy room	was	
		dry food storage area			cleaned immediately. The	linon	
		a build-up of dust. 6. A			refrigerator located near the room was cleaned immediate		
		as heavily soiled with dust			The microwave in the south	- ,-	
	1 -	articles. 7. Knobs on the			dining room was cleaned		
	1	e laden with a build-up of			immediately. The corrective		
	dried food substa	•			action taken for those reside having the potential to be aff		
		rticles were laden on the			by the same deficient practic		
	1 5. 2110a 100a pa	,, 616 164611 011 010			· · · · · · · · · · · · · · · · · · ·		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 05/24/2	LETED	
NAME OF	NAME OF PROVIDER OR SUPPLIER  BREMEN HEALTH CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL		A. BUI	STREET A	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIED TO T	05/24/2	
	food on them. Of 11. Two juice pit were stored with were still laden beverages and control of 12. Two dish can with dried spillar dish dried dish dried dish dried	ne plate was chipped. tchers and five sippy cups a clean dishes while they with remnants of ocoa. tts were heavily soiled ge and food particles.  ion of the kitchen on A.M., the following was c dishwasher had to be run te temperature was 150 cations for the machine). Thing sink (auto) had to be tes before water was hot			recur is: Dietary staff has be re-inserviced regarding kitosanitation. Facility staff has in-serviced regarding propes sanitations of refrigerators microwaves. To ensure the deficient practice does not the monitoring system established is: A Performant Improvement indicator has established which evaluate compliance with kitchen sanitation and proper sanitation and proper sanitation and proper sanitation weekly for the first month, monthly for the first quarter quarterly thereafter with restorwarded to the facility performance improvement committee for further evaluation resolution. POC Date: 66	een hen s been er and he recur, ce been s ation of es. ector or cator and sults	

PRINTED: 06/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DAT						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155474		A. BUILDING 00			COMPLETED 05/24/2011	
		100474	B. WING		ADDRESS CITY STATE TIP CORE	05/24/2	V11	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
BREMEN	I HEALTH CARE CE	ENTER	BREMEN, IN46506					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
		ager indicated in an						
	interview on 5/17/11 at 9:08 A.M., that							
		ed all dietary staff on the						
		suring the dishwasher						
	was the correct to	emperature. "I will						
	inservice all of them (staff) again."							
	B. During the environmental tour of the							
	facility on 5/20/2011 at 2:30 p.m.,							
	_	the Maintenance Director						
		sekeeping Director # 42						
	the following wa							
	1. The refrigerato	or in the Occupational						
	Therapy room wa	as observed to be soiled						
	with dust and dir	t debris.						
	_	or located near the linen						
		ed to have a spilled tan						
		bottom drawer. The						
	with food debris.	rigerator were soiled						
	with food dcolls.							
	3. The microway	e oven in the south						
		observed to be soiled						
	with dried food d							
	3.1-21(1)(3)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4EZC11

Facility ID:

000506 If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155474	B. WIN			05/24/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	OODIES LANE		
BREMEN HEALTH CARE CENTER			l	:N, IN46506			
				<u> </u>			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ſΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0425		rovide routine and					
SS=D		and biologicals to its n them under an agreement					
		.75(h) of this part. The					
		unlicensed personnel to					
		f State law permits, but only					
	under the general supervision of a licensed						
	nurse.						
	A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  The facility must employ or obtain the services						
		macist who provides					
		aspects of the provision of					
	pharmacy services	s in the facility.					
			F0	425	F-425		06/23/2011
	Based on observa	ation, interview, and				<b>t</b> o	
	record review, th	e facility failed to ensure			It is the practice of this facility ensure the highest quality of		
	the ordered medi	cations were available			is afforded our residents.	carc	
	for 1 of 12 reside	ents observed for			Consistent with this practice,	the	
	medications in a	sample of 19 and that			following has been done: The	e	
		ons were removed from			corrective action taken for the		
	•	carts in a timely manner			residents found to have beer		
		3			affected by the deficient prac		
	in 3 of 5 medicat	ion carts.			was:Resident #72's medicati order for ferrous gluconate w		
					clarified by the resident's	as	
	Resident # 1, # 5	6, # 72, and # 85			physician to read 324 mg po	ad.	
	Findings include:				Medications were re-ordered		
					received by the pharmacy for	r	
					residents #1, #56, #85 and #		
	1. The clinical re	ecord for Resident # 72			The corrective action taken f	or	
		5/18/11 at 2:00 P.M			those residents having the		
	,, as it it weaton	0,10,11 at 2.00 1.111			potential to be affected by the		
	A Diamining O 1	John J 11/24/10			same deficient practice is:No residents were affected by the		
	A Physician Orde	er, dated 11/24/10,			practice. Pharmacy has aud		
			1		practice. Friamilacy has aud	iicu	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155474 05/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 316 WOODIES LANE BREMEN HEALTH CARE CENTER BREMEN, IN46506 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE indicated, "...Ferrous Gluconate (iron) 325 all medication carts to ensure no expired meds are present and all mg..." ordered medications are available for administration. The measures During first medication pass on 5/17/11 at put into place and a systemic 9:00 A.M., LPN # 18 was observed to change made to ensure the deficient practice does not recur give Resident #72 Ferrous Gluconate is: All licensed nursing staff has 324 mg. been in-serviced on proper transcription of medication orders Interview on 5/18/11 at 4:40 P.M., the and ensuring no expired meds are present and all expired meds DON (Director of Nursing) indicated the are replaced. To ensure the pharmacy was unsure why they sent deficient practice does not recur, Ferrous Gluconate 324 mg (milligrams) the monitoring system instead of the ordered 325 mg dose. established is:A Performance Improvement indicator has been established which evaluates 2. During inspection of the medication transcription of physician orders carts, the following was observed: and routine med cart review to ensure no expired medications are present. The Director of South B medication cart on 5/18/11 at Nursing or designee will complete 3:00 p.m. weekly for the first month, monthly for the first quarter and Resident # 56: One bottle of Timolol 0.5 quarterly thereafter with results % eye drops, fill date 1/17/11, open date forwarded to the facility performance improvement 2/2/11, one bottle of Lotemax 0.5 % eye committee for further evaluation drops, fill date 12/11/10, open date 2/2/11. or resolution. POC Date: 6/23/11 Resident #85: One bottle of Flunisolide NS (nasal spray) 0.025 %, fill date 12/1/10, no open date, one Advair 500/50 (asthma medication), fill date 3/22/11, open date 3/30/11, discard date 4/28/11. 3. South A Medication Cart on 5/18/11 at 3:18 P.M.:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	155474	A. BUILDING	00 COMPLETED 05/24/2011		
		100171	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/2 1/2011	
NAME OF I	PROVIDER OR SUPPLIER			OODIES LANE		
	I HEALTH CARE CE		BREMI	EN, IN46506		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION DATE	
	Resident # 66: C	,	1110		2.112	
		edication used to help				
	\	ttack) 0.4 mg (milligram),				
	•	expiration date 3/2010.				
	4. North A Medi	cation Cart on 5/18/11 at				
	4:55 P.M.:					
	Resident # 1: Or	ne bottle Genteal gel				
	drops (eye drops), fill date 12/13/10, open					
	date 1/31/11.					
	An "Executive S	ummary of Consultant				
		dication Regimen				
	-	ed the medication carts				
	were last inspect	ed 5/9/11.				
	A facility policy	titled, "Medication				
	-	revised 10/31/10,				
		nove and dispose				
	ofoutdated"					
	A facility policy	titled "Medication				
	Administration",	revised 10/31/10,				
	indicated, "Pre	pare the medication using				
	the five right of r	nedication				
		Right medication name				
	_	ad the medication				
		in compare with the				
	prescription labe	l(s)"				
	3.1-25(a)					
	3.1-25(o)					
					<del></del>	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA				TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE			ETED	
		155474	B. WING 05/24/201			011	
			B. WINC		DDDEGG OFFI GTATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
BREMEN HEALTH CARE CENTER					ODIES LANE		
BKEMEN	N HEALTH CARE CI	ENTER		BKEME	N, IN46506		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL				E	COMPLETION
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
F0431 SS=E	of a licensed phar system of records all controlled drug enable an accurat determines that drug that an account of maintained and per Drugs and biologic be labeled in account accepted profession the appropriate accepted.	employ or obtain the services macist who establishes a of receipt and disposition of its in sufficient detail to be reconciliation; and all controlled drugs is eriodically reconciled.  Cals used in the facility must produce with currently conal principles, and include accessory and cautionary the expiration date when					
	the facility must st in locked compart temperature contro	n State and Federal laws, ore all drugs and biologicals ments under proper ols, and permit only nel to have access to the					
	permanently affixed of controlled drugstood Comprehensive Donatrol Act of 197 abuse, except which the quantity	rovide separately locked, ed compartments for storage is listed in Schedule II of the rug Abuse Prevention and 6 and other drugs subject to en the facility uses single distribution systems in stored is minimal and a be readily detected.	F0-	431	Г 424		06/23/2011
	interview, the face medications were accepted standar carts. Nitroglyce	ation, record review, and cility failed to ensure e labeled according to ds for 3 of 5 medication rin tablets were found ng information and	10		F-431  It is the practice of this facility ensure the highest quality of is afforded our residents.  Consistent with this practice, following has been done: The corrective action taken for the residents found to have been	care the e	00/25/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	A. BUILDING 00			COMPLETED	
		155474	B. WING 05/24/2011			011		
		<u> </u>	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIE	3			OODIES LANE			
BREMEN	N HEALTH CARE C	ENTER		1	EN, IN46506			
					14, 114-0000			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	` `	ACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION		
TAG	-	LSC IDENTIFYING INFORMATION)	-	TAG	•	4:	DATE	
		e found with no first open			affected by the deficient prac was:The medications for	tice		
	date. This defice	eient practice affected 3 of			residents #8 and #83 were			
	94 residents. (R	esident # 83, Resident #			reordered and received by the	ne l		
	8)				pharmacy. The corrective a			
					taken for those residents hav			
	Findings include:				the potential to be affected b	y the		
					same deficient practice is: N			
					residents were affected by th			
	During inspection of the medication carts, the following was observed:				practice. Pharmacy has aud all medication carts to ensure			
					appropriate labeling and dati			
				applicable medications wher	٠ .			
	Reflections Medication Cart:				initially opened. The measu			
					put into place and a systemic			
	One bottle of Nitroglycerin 0.4 mg, no				change made to ensure the			
	patient identifica	ation label present.			deficient practice does not re			
					is: Licensed nursing staff has			
	Interview with the	he DON (Director of			been in-serviced on ensuring			
		8/11 at 3:35 P.M., she			appropriate medication label and dating of applicable med			
	· · · · · · · · · · · · · · · · · · ·	e pharmacy checks the			when initially opened. <i>To er</i>			
	medication carts				the deficient practice does no			
	inedication carts	monuny.			recur, the monitoring system			
	0.54044	40 D.M. (1. D.C.)			established is:A Performance			
		40 P.M., the DON			Improvement indicator has b	een		
		s unable to verify who			established which evaluates			
	the bottle of Niti	roglycerin belonged to			compliance with labeling and opened as indicated. The	ı datê		
	because it was n	ot labeled appropriately.			Director of Nursing or design	iee		
					will complete indicator weekl			
	An "Executive S	Summary of Consultant			the first month, monthly for the			
	Pharmacist's Me	dication Regimen			first quarter and quarterly			
		ted the medication carts			thereafter with results forwar	ded		
	were last inspect				to the facility performance improvement committee for			
					further evaluation or			
	2. South B Med	ication Cart			resolution. POC Date: 6/23/1	11		
	2. South Bivied	ication Cart.						
	D 1	O A 1 .: . 050/50 . 611						
		One Advair 250/50, fill						
	l date 4/6/11 no c	nen date						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155474		(X2) MULTIPL  A. BUILDING  B. WING	E CONSTRUCTION  00	COM	(X3) DATE SURVEY  COMPLETED  05/24/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  316 WOODIES LANE BREMEN, IN46506					
BREMEN  (X4) ID  PREFIX  TAG	REFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL			PROVIDER'S I  X  PROVIDER'S I  (EACH CORRECTIVE CROSS-REFERENCE)	PLAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE		
	3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(k)(3) 3.1-25(k)(4) 3.1-25(k)(5)							

li l		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155474	A. BUILDING	00	COMPLETED 05/24/2011		
		199474	B. WING		03/24/2011		
NAME OF I	PROVIDER OR SUPPLIEI	₹		ADDRESS, CITY, STATE, ZIP CODE			
BREMEN	N HEALTH CARE C	ENTER	316 WOODIES LANE BREMEN, IN46506				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	ID PROVIDERS BLANGE CORRECTION			
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F0441 SS=E	Infection Control I a safe, sanitary an and to help preve transmission of di  (a) Infection Cont The facility must be Program under w  (1) Investigates, confections in the facility must be infections in the facility must be infections in the facility must be infections. Should be resident; and  (3) Maintains a recorrective actions  (b) Preventing Sp  (1) When the Infection of t	establish an Infection Control hich it - controls, and prevents acility; procedures, such as be applied to an individual cord of incidents and related to infections.  read of Infection ction Control Program resident needs isolation to d of infection, the facility					
	1	ing is indicated by accepted					
	transport linens so infection.	andle, store, process and of as to prevent the spread of					
	record review, the proper infection implemented rel	ration, interview, and me facility failed to ensure control practices were ated to lack of a 3 of 3 residents	F0441	F-441 It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with th practice, the following has be done: The corrective action ta	is en		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	A. BUILDING 00			COMPLETED	
		155474	B. WING 05/24/201		1			
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	₹		1				
5551451		ENTER		1	OODIES LANE			
BREME	N HEALTH CARE C	ENTER		BREMEN, IN46506				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	(Residents #40, #11, #27) observed for				for the residents found to ha			
	care, open/expir	ed respiratory equipment			been affected by the deficier	nt		
		Resident #27) for 1 of 1			practice was:There was no			
	`	,			negative outcome to residen			
	residents reviewed for respiratory				due to the C.N.A. not washin	~ 1		
	· ·	ically compromised			hands after removing her glo The ambu-bag was replaced			
	resident admitted	d to a C-difficile resident's			resident #27. R.N. 8 and the			
	room (Resident	#87), and improper			ADON were immediately			
	sanitation of a gi	lucometer used for 1 of 2			re-inserviced on proper use	of		
	diabetics (Resident #80) in the sample of				gloves. Resident #27 had no			
	19.				negative outcome related to	this		
17.				practice. There was no nega				
Fig. For a first Are				outcome to resident #11 rela				
	Findings include	<del>.</del>			to this practice. Resident #8			
					roommate is currently free fr	om		
	1. Resident #40's	s clinical record was			C-difficile infection and is an	oility		
	reviewed on 5/1	6/11 at 2:35 P.M., and			appropriate roommate per fa policy. L.P.N. #17 was	Cility		
	indicated diagno	ses of, but not limited to:			immediately re-educated on	the		
	history of sacral				proper sanitation/disinfection			
	I -	acular degeneration, senile			the glucometer per facility po			
	_	steoarthritis of the hips.			for resident #80. The correct			
	dementia, and of	steoartimus of the hips.			action taken for those reside	nts		
					having the potential to be aff			
		oserved providing			by the same deficient practic			
	incontinence car	re to Resident #40 on			is:All residents have the pote			
	5/18/11 at 11:35	A.M. After completing			to be affected by these pract			
		ced the soiled linen into a			All staff has been in-serviced facility policy for hand washi			
		er gloves, and left the			and proper glove use. Licen			
	1	ag. She did not wash her			staff has been re-inserviced			
		•			disinfection/sanitation of the			
	nands prior to ex	citing the resident's room.			glucometer per facility policy	and		
					placement of residents with			
					infectious processes. The			
					measures put into place and			
					systemic change made to er			
					the deficient practice does n			
					recur is: Nursing Administrat			
					will conduct an observationa			
	I		1		audit of hand washing, glove	· I		

PRINTED: 06/16/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	00	COMPLI			
		155474	B. WIN		05/24/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  316 WOODIES LANE BREMEN, IN46506					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
IAU	2. Resident #27' 5-16-2011 at 10: diagnoses includ brain injury, quavegetative state.  On 5/16/11 at 6:3 ambu-bag hangin Resident #27's be open. The open	s record was reviewed on 15 a.m. Resident #27's e, but were not limited to, driplegia, dysphagia, and 30 p.m., observed ng from IV pole next to ed. The bag was hanging dated was "12/4 @ (at)discard 12/5 @ 2100."		IAU	usage, and glucometer clear across all three shifts to ensign adherence to facility policy a procedure. ADNS, or design will review any residents with infectious processes, ongoing ensure appropriate placemed Any identified concerns will immediately corrected with the involved employee. To ensign the deficient practice does in the deficien	ure und nee, n ng, to nt. be he sure of neen ng, dents he nee ly for he	DAIE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4EZC11

Facility ID:

000506

If continuation sheet

Page 143 of 162

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155474		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE COMPI 05/24/2	LETED	
	PROVIDER OR SUPPLIEF		•	316 WC	ADDRESS, CITY, STATE, ZIP CODE DODIES LANE EN, IN46506		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
		ras sticky to the touch.					2.112
	observed while of RN #8 touched to gloves with bare sterile technique  On 5/16/11 at 6::	57 p.m., the ADON was					
	observed leaving Resident #27's room during a treatment with gloves on. The ADON returned within minutes with gloves still on. The ADON then returned to the bedside and continued to assist RN #8 with the treatment.						
	on 5/17/11 at 3:2 record indicated limited to; paraly	's record was reviewed 20 p.m. The Resident's diagnoses of, but not vsis of the lower limbs, depression, and diabetes.					
	changes to Resid						
	his feet, RN #10 spray to moisten Acticote. RN #10 placed the soiled	pen wounds on both of applied Sea Cleanse the old dressings of removed them and dressings in a small red f the bed. RN # 10					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155474	B. WIN			05/24/2	011
	PROVIDER OR SUPPLIER		•	316 WC	ADDRESS, CITY, STATE, ZIP CODE DODIES LANE EN, IN46506		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	ed gloves and on another pair without ds prior to donning clean					
	the open wounds buttocks, the ope Resident's knee a removed the soile them in the red b						
	were observed sire counter by his sire on the resident's observed to grab Acticote dressing	soiled Acticote dressings tting on the residents and one was observed floor. RN #10 was the soiled squares of as with her bare hands in the red trash bags.					
	reviewed on 5/19	ses of, but not limited to, al cord disease,					
	Department Note	vsician Emergency ", dated 2/16/11, fax 11, indicated, "Hepatitis					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155474		Ì	LDING	NSTRUCTION 00	COM	TE SURVEY  IPLETED  1/2011	
	PROVIDER OR SUPPLIER		<u></u>	STREET A	ODDIES LANE N, IN46506	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE L DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	performed by (N "Hepatitis Crig universal precau Resident # 87 wa private room on of Hepatitis C. I room with a resid case of Clostridia  Interview on 5/1 ADON indicated diagnosis of C di isolation and tha resident who is it the same room.  On 5/19/11 at 4: indicated a reside compromised we be placed in the who has C diff. diagnosis of C di isolation.  A facility policy revised 10/31/06 "approximately infections. This remains contagic cirrhosis, cancer	as admitted to a semi 2/24/11 with a diagnosis He was admitted into this dent who had an active am Difficile (C diff).  9/11 at 4:00 P.M., the I that a resident with a aff would warrant at she would not place a mmunocompromised in  10 P.M., RN # 20 ent who is severely ould not be appropriate to same room with someone She further indicated a aff would warrant  titled "Hepatitis C," , indicated, / 50 % develop chronic subset of residents ous and is at risk for					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S	ETED	
		155474	B. WIN			05/24/2	011
	PROVIDER OR SUPPLIER		-	316 WC	DODIES LANE N, IN46506		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	following infection	on is not known"					
	Difficile,", revi "Clostridium diff put into place to p C-DifThose th difficile infection includeImmuno conditionsUse of PrecautionsPlace private rooms. If available, these p roomswith other difficile-associate	Contact ce these patients in f private rooms are not eatients can be placed in er patients with C. ed disease					
	5/16/11 at 4:20 P an Accu Check (I Resident # 80. A test, she carried t out to the medica	nedication pass on  .M., LPN # 17 performed blood sugar test) on  .fter completion of the he Accu Check monitor ation cart in the hallway black pouch on the top					
	Accu Check on the gathered her supported to the support of the sup	N # 17 prepared to do a he next resident. She blies from the medication e Accu Check monitor applies into the resident's hitation of the monitor. A. LPN # 17 was rn to the medication cart hen cleaned the monitor					

AND PLAN OF CORRECTION IDENTI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		ISTRUCTION 00	(X3) DATE S COMPL	ETED
		155474	B. WINC	·		05/24/2	011
	ROVIDER OR SUPPLIER			316 WO	ODRESS, CITY, STATE, ZIP CODE ODIES LANE		
BREMEN	I HEALTH CARE CE	ENTER		BREMEN	N, IN46506		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	with a 70 % Alco	onoi Pad.					
	4:50 P.M., she in clean the Accu C Alcohol Pads.  A facility policy Blood Glucose 10/31/10, indicat coverusing a 10	PN # 17 on 5/16/11 at dicated the policy is to heck monitors with titled, "SureStepFlexx Cleaning," revised ed, " Wash inside 0 % bleach solutionClean the outside of the					
	meter with a 10 %	% bleach solution in-between each resident					
F0465 SS=D	sanitary, and comfresidents, staff and Based on observation facility failed to a was kept clean and staff and 91 of 9 the facility.  Findings include:  During observation	ations and interview, the ensure the facility kitchen and sanitary for dietary 4 residents residing in	F04	465	F-465 It is the practice of this facility ensure the highest quality of is afforded our residents. Consistent with this practice, following has been done: The corrective action taken for the residents found to have been affected by the deficient practice. The affected by this practice. If loors in the dry food storage were cleaned immediately.	the tice to The area	06/23/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				onstruction 00	(X3) DATE S COMPL		
THEFTER	or conduction	155474	- 1	LDING		05/24/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF I	PROVIDER OR SUPPLIE	R		1	OODIES LANE		
BREMEN	N HEALTH CARE C	ENTER		1	EN, IN46506		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		lry food storage area had	-	IAG	sprinkler heads were cleaned	1	DATE
		t under the bottom			immediately and the facility	_	
	shelves.	t under the bottom			purchased new ventilation file		
		n filters and sprinkler			The range along with the floo		
		den with grease and dust.			around the range was cleane immediately. The sprinkler h		
	1	ge had a build-up of			in the kitchen were cleaned	Joaqu	
		ne back of it, including the			immediately. The ceiling hea		
	floor behind and				was removed. The sippy cup		
		dust on the sprinkler			washed immediately. The w in the kitchen and outside the		
	heads on the kite	_			kitchen were cleaned	-	
		er was heavily laden with			immediately. The corrective		
	dust.	er was neavity faden with			action taken for those reside		
		yog haak in a aarmar on			having the potential to be aff by the same deficient practic		
		vas back in a corner on			is:No other residents were	-	
		he dishwashing sink.			affected by this practice. <i>The</i>	,	
		ritchen and in the food			measures put into place and		
	1 "	outside the kitchen were			systemic change made to en		
	laden with dried	drippings.			the deficient practice does no recur is: Dietary staff has bee		
	<b>.</b>	:4. 6. 1. //2.4			re-inserviced regarding kitch		
	_	w with Cook #34 on			sanitation. <i>To ensure the</i>		
		A.M., she indicated the			deficient practice does not re	cur,	
		oughly cleaned the week			the monitoring system		
	prior.				established is:A Performance Improvement indicator has b		
					established which evaluates	CCII	
	3.1-19(f)				compliance with maintaining	а	
					clean and safe environment.		
					Nutritional Service Director of		
					designee will complete indica weekly for the first month,	וטו	
					monthly for the first quarter a	ind	
					quarterly thereafter with resu	Its	
					forwarded to the facility		
					performance improvement committee for further evaluate	ion	
					or resolution. POC Date: 6/2		

f ·		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	(X2) M A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE ( COMPL <b>05/24/2</b>	ETED
	PROVIDER OR SUPPLIER			316 WO	DODIES LANE N, IN46506		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Ē	(X5) COMPLETION
F0514 SS=D	The facility must meach resident in accomplete; accurate accessible; and sy.  The clinical record information to identhe resident's asse and services provipreadmission scressate; and progress Based on record interview, the factoresident records a legible for 3 of 3 proper document (Residents: # 11, Findings include  1. Resident # 11's Madministration received insulin leading of the legible for 3 of 3 proper document (Residents: # 11, Findings include)  1. Resident # 11's Madministration received insulin leading for the legible for 3 of 3 proper document (Resident # 11's Madministration received insulin leading for the legible for 3 of 3 proper document (Resident # 11's Madministration received insulin leading for the legible for 3 of 3 proper document (Resident # 11's Madministration received insulin leading for the legible for 3 of 3 proper document (Resident # 11's Madministration received insulin leading for the legible for 3 of 3 proper document (Resident # 11's Madministration received insulin leading for the legible for 3 of 3 proper document (Resident # 11's Madministration received insulin leading for the legible for 3 of 3 proper document (Resident # 11's Madministration received insulin leading for the legible for 3 of 3 proper document (Resident # 11's Madministration received insulin leading for the legible for 3 of 3 proper document (Resident # 11's Madministration received insulin leading for the legible for 3 of 3 proper document (Resident # 11's Madministration received insulin leading for the legible for 3 of 3 proper document (Resident # 11's Madministration received insulin leading for the legible for 3 of 3 proper document (Resident # 11's Madministration received insulin leading for the legible for 3 of 3 proper document (Resident # 11's Madministration received insulin leading for the legible for 3 of 3 proper document (Resident # 11's Madministration received insulin leading for the legible for 3 of 3 proper document (Resident # 11's Madministration received insulin leading for the legibl	review, observation and cility failed to ensure were complete and residents reviewed for ation in a sample of 19. # 3, and # 80)  s record was reviewed on .m. The Resident's record ses of, but not limited to; ower limbs, pressure in, and diabetes.  MAR (medication cord) indicated he by way of sliding scale.	F0	TAG	F-514  It is the practice of this facility ensure the highest quality of is afforded our residents.  Consistent with this practice, following has been done: The corrective action taken for the residents found to have beer affected by the deficient practice, was:All glucometer checks we completed as ordered for residing scale. Resident #3 does not have physician for glucometering at 12pm. and 6pm. To resident does receive sliding scale insulin coverage for glucometer testing at 6am and 4pm. Per review of resident MAR, the correct amount on insulin was administered for glucometer results on 3/21/13/24/11, and 3/25/11. Resides physician was informed of the medication variance related to Diltiazem and no new orders were received. The physicia was also notified of oxygen	to care the ere ere ident of es meter his	DATE 06/23/2011

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155474	1			05/24/2	
		155474	B. WIN			03/24/2	011
NAME OF I	PROVIDER OR SUPPLIEI	2		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	ROVIDER OR SOLI EIE			316 WC	OODIES LANE		
BREMEN	N HEALTH CARE C	ENTER		BREME	EN, IN46506		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	units"		Ī		saturation levels not obtaine	d as	
					ordered on four occasions ir	the	
		26 2011 : 1: 1			month of May and no new o	rders	
		May 2011, indicated on			were received. The physiciar	n has	
	5/6/11 the reside	ent's blood glucose was			been notified for resident #8	0	
	151. The MAR 1	acked documentation to			relative to elevated blood su	gars	
		esident received his			with no new orders received	.The	
					corrective action taken for th	ose	
	sliding scale inst	ulin of 33 units.			residents having the potentia	al to	
					be affected by the same def		
	The MAR lacke	d documentation on			practice is:A facility wide aud	dit	
	5/4/11 and 5/10/	11 of a glucose result, or			was conducted to identify the	ose	
		_			residents requiring sliding so	cale	
	I -	inistered. Both dates were			insulin. A facility wide medic	cation	
	left blank.				administration record and		
					treatment administration rec	ord	
	During an interv	view with LPN # 3 on			audit for the month of June h	nas	
					been conducted to review		
	_	o.m., regarding the blanks			compliance with all medicati	ons	
	in the MAR, she	looked at the MAR and			requiring specialized parame	eters.	
	indicated she wa	as not the nurse who left			Any variances to prescribed		
	the blanks and in	ndicated the			treatment regime will be rep	orted	
		should have been			to the physician for further re	eview	
		mould have been			and recommendation. The f	acility	
	completed.				created a blood sugar/insulii	า	
					binder for easy monitoring o	f	
					correct administration, and		
					documentation of glucomete		
					results, routine insulin, and s	•	
					scale coverage. The meas		
					put into place and a systemi	C	
					change made to ensure the		
					deficient practice does not re		
					is: Licensed nursing staff ha		
					been in-serviced on the usage	ge of	
					the new blood sugar/insulin		
					binders which will help moni	tor	
					correct administration, and		
					documentation of glucomete		
					results, routine insulin, and s	-	
					scale coverage. Licensed st		
	1		1		will be re-inserviced on follow	wina	l l

l	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE COMPI 05/24/2	LETED
	PROVIDER OR SUPPLIER		316 W0	ADDRESS, CITY, STATE, ZIP CODE DODIES LANE EN, IN46506	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE RIATE	(X5) COMPLETION DATE
	5-19-2011 at 2:0 diagnoses includ Diabetes Mellituright femur fract  The "Medication of March 2011 st blood sugar 0-15 units, 201-250= 301-350= 12 unit call MD if blood greater than 400.	s record was reviewed on 0 p.m. Resident #3's e, but were not limited to, s, dementia, history of a ure, and depression.  Record" for the month tated, "Sliding scale, if 10=0 units, 151-200=3 6 units, 251-300= 9 units, ts, 351-400= 14 units, sugar less than 60 or"		physician orders related to obtaining oxygen saturatic and adherence to ordered directives/parameters for specified medications. To ensure the deficient practic not recur, the monitoring sestablished is: A Performa Improvement indicator has established which evaluat compliance with following orders and oxygen satura levels, and medications readditional monitoring. The Director of Nursing or des will complete indicator we the first month, monthly for first quarter and quarterly thereafter with results forve to the facility performance improvement committee for further evaluation or resolution. POC Date: 6/2	on levels  oce does eystem nce s been es insulin cion quiring e gnee ekly for r the	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155474	- 1	LDING	00	05/24/2	
		100474	B. WIN		DDDESS CITY STATE ZID CODE	00/2-1/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BREMEN	N HEALTH CARE CE	ENTER		1	EN, IN46506		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE!)		DATE
		ent #3's blood sugar was					
	not taken and no	coverage was given.					
	The "Medication	Record" on 3/24/11 at					
	6:00 p.m., Reside	ent #3's blood sugar was					
	not taken and no	coverage was given.					
	The "Mediceties	Record" on 3/25/11 at					
		lent #3's blood sugar was					
	1 *	coverage was given.					
	not taken and no	coverage was given.					
	The "Medication	Record" for the month					
	of April 2011 sta	ted, "Diltiazem (a					
	medication used	to treat an irregular heart					
	rhythm) 60 mg.	Give 1 tablet by mouth					
	every 6 hours. D	x (diagnosis): AFIB					
	(atrial fibrillation	n) *Hold if SBP (systolic					
	blood pressure) <	<90"					
	The "Medication	Record" indicated that					
		od pressure was not					
		ng the month of April and					
	no medication wa						
	The "Medication	Record" for the month					
	1 *	ed, "Oxygen per nasal					
		oxygen saturation above					
	90% may wean a	s tolerated"					
	The "Medication	Record" indicated a biox					
		vel) was not taken 4					
	`	month of May 2011.					
	diffes during the	monui di way 2011.					
	An interview was	s completed on 5/19/2011					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE COMPI <b>05/24/2</b>	LETED
	PROVIDER OR SUPPLIER		B. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE DODIES LANE EN, IN46506		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	at 2:30 p.m., with indicated that if to finsulin given with chart she work done. There is no put documentation of the clinical reviewed on 5/16 indicated diagnoral diabetes mellitus and peripheral new A Physician Orderindicated, "GludailySliding Sc 60-150=0 units, 201-250=8 units, 301-350=14 units MD if blood sugathan 350"  Review of the Fee (Medication Admindicated Reside follows:  2/12/11 at 4:00 Precord lacked do Review of the Aphlood sugars as followed as a fee of the product of the product of the Aphlood sugars as followed as a fee of the product of the p	he blood sugar or amount was not documented in ald assume it was not to other book they use to on.  ecord for Resident # 80 6/11 at 10:45 A.M., sees of, but not limited to, acute kidney failure, europathy.  er, dated 2/5/11, cometers twice tale. If blood sugar 151-200=4 units, 251-300=12 units, s, 351-400=16 units, Call ar less than 60 or greater  ebruary 2011, MAR ministration Record) at # 80's blood sugars as					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155474	B. WIN			05/24/2011
NAME OF F	PROVIDER OR SUPPLIER	<b>!</b>	'	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				1	OODIES LANE	
BREMEN	NHEALTH CARE CI	ENTER		BREME	EN, IN46506	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
	record lacked do	cumentation of coverage.				
		ay 1 through 17, 2011,				
		blood sugar on 5/17/11 at				
	6:00 A.M. was 1	78. The clinical record				
	lacked document	tation of the amount of				
	coverage given.					
	The February 20	11, April 2011, and May				
	1 through 17, 20	11, MAR indicated				
	Resident # 80's r	ecord lacked clinical				
	documentation o	n three occasions.				
	Resident # 80's C	Care Plan, dated 5/19/11,				
	indicated, "Me	dication as ordered. See				
	Physician's Orde					
	1 -	Care Plan, dated 5/19/11,				
		dication as ordered"				
	Interview on 5/2	0/11 at 9:15 A.M., the				
		at Director of Nursing)				
	`	s unable to verify if the				
		coverage on the above				
	dates.					
	A facility policy	titled "Medication				
		revised 10/31/10,				
	indicated, "Doo					
		of the medicationon the				
	MAR"	or the medicationon the				
	1VI/XIV					
	3.1-50(a)(1)					
	3.1-50(a)(1) 3.1-50(a)(2)					
	] 3.1-30(a)(2)					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155474	B. WING		05/24/2011
	PROVIDER OR SUPPLIER		316 WC	ADDRESS, CITY, STATE, ZIP CODE DODIES LANE EN, IN46506	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
F0516 SS=B	resident-identifiable The facility may revesident-identifiable accordance with a agent agrees not to information except itself is permitted to the facility must so information against unauthorized use. Based on observation of facility failed to the did not have according to the medical repossession. This potential to affect residents whose instored in the medical repossession. This potential to affect residents whose instored in the medical repossession. This potential to affect residents whose instored in the medical repossession. This potential to affect residents whose instored in the medical repossession in the medical repossession. This potential to affect residents whose instance in the medical repossession in the medical repossession in the medical reposition of facility on 5/20/1 accompanied by # 41 and the Hou an observation of room was requested.  An observation of the facility may be a supplied to the facility of the	elease information that is le to an agent only in contract under which the o use or disclose the to the extent the facility o do so.  afeguard clinical record et loss, destruction, or lation and interview, the ensure unlicensed staff less to resident records usekeeper having the key cord room in his deficiency has the trany of the 94 of 94 medical records are lical record room.  In the Maintenance Director is sekeeping Director # 42, if the medical records ted.	F0516	F-516  It is the practice of this facilit ensure the highest quality of is afforded our residents.  Consistent with this practice following has been done: The corrective action taken for the residents found to have been affected by the deficient practice. The corrective action taken for those reside having the potential to be affected having the potential to be affected, therefore, this plan of correct applies to all residents curred residing in the facility. The measures put into place and systemic change made to enter the deficient practice does not recur is: The lock to the medical records room has been charn No unlicensed or uncertified has a key or access to the	the e e e n ctice ted tive nts fected e have tion ntly f a assure ot dical aged.

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155474 05/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 316 WOODIES LANE BREMEN HEALTH CARE CENTER BREMEN, IN46506 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE secured medical records office. in his possession and open the locked All staff have bee re-educated medical records room door. relative to the necessity of safeguarding medical records. To An observation was made of one ensure the deficient practice does resident's medical record sitting on a not recur, the monitoring system established is: A Performance table. The other records were observed to Improvement indicator has been be located in metal file cabinets. Three of established which evaluates the file drawers were not locked and able compliance with who has access to be pulled open when checked. to the medical records office. The Director of Nursing or designee will complete indicator During an interview with the Housekeeper weekly for the first month, on 5/20/11 at 3:00 p.m., regarding having monthly for the first quarter and the key to the medical record room, he quarterly thereafter with results forwarded to the facility indicated he needed to have a key because performance improvement there are times he needed to get in there. committee for further evaluation or resolution. POC Date: 6/23/11 3.1-50(d)F9999 F9999 3.1-13 ADMINISTRATION AND 06/23/2011 F-9999 MANAGEMENT It is the practice of this facility to ensure the highest quality of care (g) The administrator is responsible for is afforded our residents. the overall management of the facility, but Consistent with this practice, the following has been done: The shall not function as a departmental corrective action taken for the supervisor, for example, director of residents found to have been nursing or food service supervisor, during affected by the deficient practice the same hours. The responsibilities of the was: No residents were found to have been affected by lack of administrator shall include, but are not reporting of the events to limited to, the following: (1) Immediately ISDH. The corrective action taken informing the division by telephone. for those residents having the followed by written notice within potential to be affected by the same deficient practice is:The twenty-four (24) hours, of unusual

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
155474		155474	B. WIN			05/24/2011	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					OODIES LANE		
BREMEN HEALTH CARE CENTER				1	N, IN46506		
(X4) ID		TATEMENT OF DEFICIENCIES	_	ID	,		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE	
-		directly threaten the		-	Event Log and event reports	for	
		or health of the resident or			the last 30 days were audited		
	1			identify if any events met the			
	· ·	ing, but not limited to,			criteria for reporting to ISDH.		
	any: (D) major a	ccidents.			measures put into place and a systemic change made to ensure the deficient practice does not		
	This rule was no	t met as evidenced by:					
					recur is: The facility will report resident unusual occurrence:		
	Based on intervi	ews and record review,			accordance with the Indiana State		
	the facility failed	to report significant			Department of Health Report		
	injuries, which resulted in fractures, to the				Unusual Occurrence policy		
					effective 01/25/2006.The		
	proper State authorities. This deficient				Executive Director and Direc	tor of	
	practice affected 2 of 3 residents				Nursing Services will be		
	(Residents: #40, #58) in the sample of 19				in-serviced relative to the Un Occurrence guidelines. <i>To</i>	usuai	
	and 1 of 1 (Resident #3) residents reviewed with significant injuries in the supplemental sample of 31.				ensure the deficient practice	does	
					not recur, the monitoring system		
					established is:A Performance		
					Improvement indicator has b	een	
	Findings include	:			established which evaluates		
					compliance with reporting		
	1   Resident #40	's clinical record was			reportable incidents to the In		
	reviewed on 5/16/11 at 2:35 P.M. and indicated diagnoses of, but not limited to: history of sacral/pelvic fracture, osteoporosis, macular degeneration, senile				State Department in accorda with the Unusual Reporting	ince	
					Occurrence guidelines. The		
					Executive Director or designed	ee	
					will complete indicator weekl		
					the first month, monthly for the		
	dementia, and os	steoarthritis of the hips.			first quarter and quarterly		
					thereafter with results forwar	ded	
	During initial to	ur of the locked dementia			to the facility performance		
	unit on 5/16/11 a	at 7:00 A.M., while			improvement committee for further evaluation or		
		LPN # 2, she indicated			resolution. POC Date: 6/23/1	<sub>1</sub>	
		d sustained an irreparable			220.00.00		
		ip from a recent fall on					
	the unit. Residen	-					
	-	dicated she was having					
	pain at the time.						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	(X2) M A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE SU COMPLET 05/24/20	
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE		
BREMEN HEALTH CARE CENTER					OODIES LANE N, IN46506		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	dated 5/3/11, index Fall with significant Adverse effect: I hipPain R hip. lounge area on a The report indication and the dementia unimple of the d	d in an interview on P.M., Resident #40 fell sofa. "There were two they were busy at the dion of the dementia unit 20 A.M., the nurse's rived to have a windowed the nurse from Resident of the fall.  2's Notes indicated the P.MUp with assist of one					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ·		ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE S COMPLI			
155474		B. WIN			05/24/20	011			
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE				
				316 WOODIES LANE					
	I HEALTH CARE CE				EN, IN46506				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)		
TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE		
		m. Disengaged her							
		r. Observed standing in							
		to go to rm (room). Res.							
		et (and) fell to floor on							
	R side"								
	2. Resident #3's	record was reviewed on							
	5-19-2011 at 2:00	0 p.m. Resident #3's							
	diagnoses include, but were not limited to,								
		sion, and Diabetes							
	Mellitus.								
	TI UD :1 4 F	. D W. 1.1 . H							
	The "Resident Event Report Worksheet,"								
	dated 6/25/10 at 7:00 p.m., stated, "had								
	been a 2 assist (two person assist) c (with)								
	no wt (weight) bearing prior to this.								
	Therapist also asked for w/c (wheelchair) pedals to be removed from w/cto try to								
	propel w/cJust outside the DR(dining room) door (Name) Resident #3 dropped her R (right) leg stopping the w/c, . The nurse assessed immediately + (and) R leg was at a 90 degree angle but previously								
	_	legree angle c brace on.							
	X-rays 6/25 ER-	Negative report.							
	Returned to facil	ity, kept on bedrest per							
	dtr (daughter) red	quest until MD							
		MD in $6/26 + \text{had}$							
		eread + Dr (Name) noted							
	*	(fracture) of the Distal							
	Femur. Resident	sent to (Name)							
	Hospital								

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474		(X2) M A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE: COMPL 05/24/2	ETED		
NAME OF PROVIDER OR SUPPLIER BREMEN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 316 WOODIES LANE BREMEN, IN46506					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	6/27/10, (untime South DR (dining residents back to (Name) Resident South DR trying behind herI toll She said ok. I probable the suddenly came to in pain. I come as w/c and saw she w/c. Both legs wabout a 90 degre up the w/c so as asked her why sher w/c. She said (resident) couldn't from floor so I concentration (sic). I turned he took her back to (complained of) what happened to was unaware the didn't have her leg pushing her"  The "Rehab Come 6/24/10, (untime leg rests (effective reviewed on 5/16).	rogress Notes," dated d), stated, "I was in the g room) transporting their rooms/units.  #3 was in the middle of to propel herself. I was d her I would push her.  ropelled her out into the e doors when the w/c o stop and she yelled out around to the front of the had no leg lifts on her were bent at the knee in e sitting angle. I backed to straighten her legs and he didn't have leg lifts on d she didn't know. Res  I't pick up either leg/foot bould propel her forwards for w/c around et (and)  her unit/room. Res c/o her leg hurt. I reported to her nurse (Name). I  (Name) Resident #3  reg lifts when I began  munication Slip" dated d), stated, "Discontinue for 6/25/10)"						

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		155474	B. WING			05/24/2	011	
NAME OF PROVIDER OR SUPPLIER  BREMEN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  316 WOODIES LANE  BREMEN, IN46506					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			ιΤΕ		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE	
	-	nentia with behaviors, d hypothyroidism.						
	During initial tour of the South A Hall on 5/16/11 at 6:35 A.M., LPN # 16 identified Resident # 58 as having a right hip fracture from a fall.							
	Review of a "Re Worksheet", date "Reported to S HospitalYesl injuryFracture  Review of the st documentation or reported as mandal Interview on 5/1 DON indicated s	sident Event Report ed 1/31/11, indicated stateNoTransferred to Fall with significant left femur" ate reportable's lacked of the incident being						